Jurisdictional Plan for HIV Prevention in Baltimore City

January 1, 2012 – December 31, 2016

Vision

Baltimore City will become a community where new HIV infections are rare, where HIV-infected individuals regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to a coordinated system of HIV prevention and care, that is high-quality, life-preserving care, free of stigma and discrimination.

Mission

The mission of the Baltimore City Health Departments Comprehensive HIV Prevention and Care Services Plan for 2012 – 2014 is to work in partnership with the broader Baltimore community to provide an effective system of HIV prevention and care services that best meets the needs of populations infected with, affected by, or at risk for HIV.

Contributors

Baltimore City Health Department
Baltimore City HIV Planning Group and Commission (HPG):
- Corrections Workgroup
- Pre-Exposure Prophylaxis Workgroup

Department of Health and Mental Hygiene, Prevention and Health Promotion Administration
Johns Hopkins Center for Child and Community Health Research

Table of Contents

* - Areas marked with an asterisk* have been updated as of September 2014

1. Overview of Baltimore City

Baltimore is a classic tale of two cities. One is a city of vibrant neighborhoods, a city rich in local tradition – jazz icons, two major professional sports franchises, a history of major steel production, a robust shipping industry and the oldest continuously operating municipal health department in the country. This same city is home to two major nationally and internationally recognized research and treatment centers for HIV. The other is a city with significant socio-economic characteristics that counter these assets and fuel the alarming HIV epidemic where some 2% of Baltimore's population is HIV infected. These characteristics include: broader racial health disparities, chronic poverty, low rates of formal education, contributing behavioral factors, and barriers to preventive and treatment services.

Baltimore and its surrounding counties (the Towson EMA) ranked 3rd among major metropolitan areas in the nation for people living with HIV/AIDS. Baltimore accounts for only 25% of the EMA population but 77% of all those living with HIV/AIDS in the EMA (2010). Regarding race, city and state data indicate that the HIV epidemic is impacting Baltimore's African American population at an alarming rate. Over 63% of Baltimoreans are African American, but they disproportionately represent 83% of all existing HIV infections in the City. Then there is poverty. According to the 2010 census, one in four Baltimoreans live in poverty. Other city statistics indicate that 47% do not have a high school degree; 75% do not have a bachelor degree or more; 16.5% (second highest in the state) do not have health insurance; and the highest unemployment rate in Maryland (11.3%, 2011. Injection drug use continues to fuel the HIV epidemic in Baltimore. Unlike most other urban cities, heroin usage has not declined in Baltimore and was associated with 184 overdoses in Baltimore in 2006. Community service capacity is also an issue. Baltimore has a paucity of high capacity community-based organizations to participate in the fight against this epidemic. The coming together of all these socio-economic determinants of health – poverty, injection drug use, low education, unemployment – contribute to the HIV epidemic in Baltimore.

Recognizing the special characteristics of the HIV epidemic in Baltimore, the Baltimore City Health Department (BCHD) has undertaken activities designed to respond to them,

especially reducing racial health disparities. BCHD has developed key partnerships with community based organizations, community health centers, and academic institutions to increase access to testing, aggressive care linkage with same-day referrals, and transportation at the time of diagnosis. BCHD funds community organizations, non-traditional partners, and agencies with the demonstrated credibility to serve hard to reach populations– e.g., men who have sex with men (MSM), transgendered individuals, racial minorities, and injections drug users – to expand testing and care to those most in need. BCHD provides community-based HIV testing through a broad mobile van outreach strategy – six days and five nights a week – targeting high-prevalence neighborhoods and populations at greatest risk of HIV infection. BCHD also participates in four national HIV awareness and testing campaigns customized to high-risk populations and supports testing in emergency departments for the general population.

Additionally, BCHD is committed to structural and policy changes that address some of the issues confronting populations affected by HIV/AIDS. The Mayor and Health Commissioner launched *Healthy Baltimore 2015*, the city's major health policy agenda, which targets 10 key areas and their social determinants of health. *Healthy Baltimore 2015* includes goals on HIV/STDs for the City.

The BCHD Comprehensive Plan incorporates strategies to expand collaboration both within and outside the health department. By reorganizing HIV/STD services within the Bureau, BCHD seeks to enhance prevention and treatment, promote collaboration through community partnerships, reduce structural barriers to testing and care, undertake policy initiatives that can further reach the most at-risk populations, and increase access to BCHD's key services for the neediest populations.

In addition, BCHD requires all organizations supported through our grant making to implement all HIV screening and partner services in accordance with national standards on culturally and linguistically appropriate services (CLAS) and limited English proficiency policies. To support the provision of culturally and linguistically appropriate services, BCHD will encourage use of DHMH's comprehensive training and technical assistance that can be made available to agencies

and non-profits. Additionally, DHMH staff developed a cultural competence packet, and BCHD disseminates this packet to all new grantees/sites as a component of their orientation. This packet defines cultural competence, describes the national CLAS Standards for service provision, and provides guidance for implementing these standards. Finally, the cultural and linguistic competence of all services will be monitored through site visits and regular evaluation of the staff and programs.

2. The State of HIV in Baltimore City

2.1 Epidemiologic Picture and Disease Burden

Baltimore City, Maryland is home to one of the most severe HIV/AIDS epidemics in the United States. As of December 2009, an estimated 13,047 (1 in 48) Baltimoreans were known to be living with HIV/AIDS, representing a burden of disease 7.5 times higher than the national average. Compared to other metropolitan areas in the US, the Baltimore-Towson metropolitan statistical area (MSA) had the third highest rate of persons living with HIV/AIDS (PLWHA) and the fifth highest rate of new HIV diagnoses. Within Maryland, HIV/AIDS is highly concentrated in Baltimore: 44% and 74% of PLWHA in the state and the Baltimore-Towson MSA, respectively, reside in the City. Similarly, 30% and 53% of persons newly diagnosed with HIV in the state and MSA are from Baltimore City.

In 2007, Maryland transitioned from anonymous to confidential names-based reporting. Prior to 2007, the number of new HIV diagnoses reported annually was relatively stable; however, in recent years, the number of new HIV diagnoses has declined, though it is unclear how much of this decline is attributable to improved reporting. Nonetheless, in 2010, the rate of new HIV diagnoses in Baltimore was five times the national rate (77.6 per 100,000 vs. 16.3 per 100,000 almost three times that for all of Maryland (30.0 per 100,000).

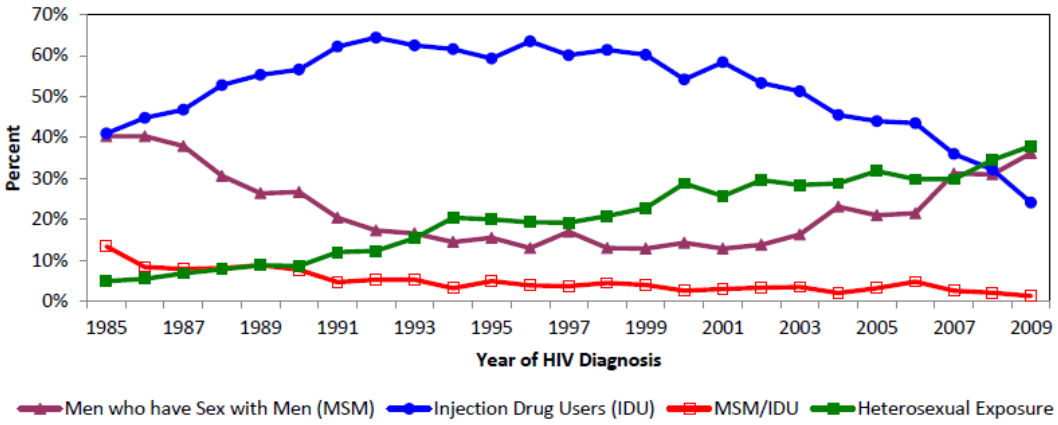
Since the late 1990s, when antiretroviral therapy became widely available, the number of reported AIDS cases each year has steadily declined. In 2008, the Maryland Department of Health and Mental Hygiene received reports for 235 AIDS cases, representing a 78% decline

from its peak in 1993 of 1,087 cases. Despite the increased survival among PLWHA who are able to access treatment, HIV/AIDS remained the 4th leading cause of the death among adults in Baltimore between 2000-2010, and the 3rd leading cause of death among 25-64 year olds.

In Baltimore, like other urban areas in the United States, poverty, certain demographic groups (African-Americans and men who have sex with men (MSM)) and high-risk behaviors such as injecting drug use (IDU) are strongly associated with an increased risk of acquiring HIV. Given the City's elevated poverty rate and ongoing injection drug use epidemic, combined with its recent syphilis outbreak among young, African-American MSM, it not surprising that HIV/AIDS is concentrated among African-Americans, high-risk groups and in poor neighborhoods. Indeed, HIV/AIDS is one of the City's largest racial health disparities: 85% of adults and adolescents living with HIV/AIDS in 2010 were African-Americans while only 62% of Baltimore's adult population Baltimore is African-American.

Injection drug use remains an important source of infection in the City – 52% of PLWHA had a history of IDU. However, the proportion of new diagnoses attributed to IDU has been declining since 2001, and the majority of transmission is now thought to be sexual rather than parenteral. (See chart below.) In 2009, three-quarters of new HIV diagnoses were attributed to sexual transmission (38% MSM and 38% high-risk heterosexual). Of particular concern is the ongoing syphilis epidemic among young (aged 25 years and younger), African-American MSM and the high rate of HIV co-infection among syphilis cases.

Percent by Exposure Category of Adult/Adolescent Reported HIV Cases, Age 13+ at HIV Diagnosis, with or without an AIDS Diagnosis (Adult/Adolescent Reported HIV Diagnoses) and with Reported Exposure Category by Year of HIV Diagnosis from 1985 through 2009, as Reported by Name through 12/31/10

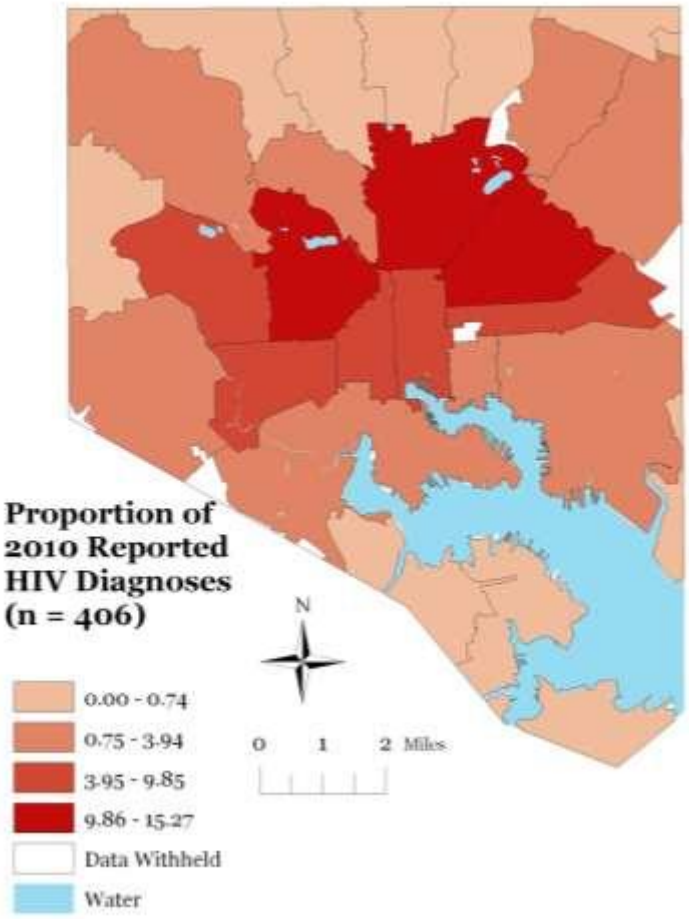


*Cases reported through 12/31/2011. Source: Maryland DHMH. HIV/AIDS in Baltimore City: And Epidemiologic Profile.

In Baltimore, HIV/AIDS is also strongly concentrated geographically. While there are 30 zip codes within Baltimore City, 37.3% of all PLWHA reside within just four zip codes. New diagnoses are even more strongly concentrated: in 2010, 43.4% of all new diagnoses reported in Baltimore were among persons residing in one of three zip codes. While some of this geographic concentration may reflect some ascertainment bias (more cases are found in areas targeted by community outreach efforts), these areas also suffer from a disproportionate burden of other sexually transmitted infections and several socio-economic determinants of health: drug use, crime, poverty, and unemployment.

In 2010, for example, there were 406 newly diagnosed HIV cases in Baltimore City. Of these cases, 98.7% could be linked to zip codes. And of these 43.3% were located in just 3 zip codes. The following map shows the distribution of all 406 cases:

Distribution of Reported HIV diagnoses among Baltimore adults (aged 13 and older) by zip code in 2010.



While nationally an estimated 20% of HIV-positive persons are unaware of their status, the extent of undiagnosed infection in Baltimore, particularly among persons at high-risk for infection, may be more severe. Data from the most recent cycles of the Baltimore site of the National HIV Behavioral Surveillance System showed that 48% of IDU, 63% of high-risk heterosexuals and 67% of MSM were unaware of their HIV-infection. Unfortunately, a substantial proportion of those who do learn their status, are diagnosed late – nearly a quarter (23%) of persons newly diagnosed with HIV in 2009 developed AIDS within one year of their HIV diagnosis - which has significant repercussions not only for the patient's health but also for ongoing transmission throughout the city.

2.2 Current State of HIV in Baltimore[1]*

The HIV/AIDS epidemic in Baltimore City is still ongoing and persistent. Compared to other metropolitan areas in the United States, the Baltimore-Towson area ranked 6th in the nation for people living with HIV/AIDS.

Table 1: Estimated Adult HIV Diagnoses Ranked by Rates, 2011[2]

Metropolitan Area	Cases	Rate per 100,000
1. Miami, FL	2,606	46.0
2. New Orleans-Metairie-Kenner, LA	513	43.0
3. Baton Rouge, LA	336	41.6
4. Jackson, MS	200	36.7
5. Washington, DC-VA-MD-WV	1,969	34.5
6. Baltimore-Towson, MD	922	33.8
Maryland State Total	1,783	30.0
United States	48,298	16.3

In 2012, 29% of individuals diagnosed with HIV and 41% of individuals living with HIV in Maryland resided in Baltimore City.

[1] Unless otherwise specified, data is from the Maryland Department of Health and Mental Hygiene (MD DHMH). *Baltimore City HIV/AIDS Epidemiological Profile, Fourth Quarter 2012*

[2] Source: MD DHMH. *HIV in Maryland.*

Figure 1: Maryland Adult/Adolescent Living HIV Cases by Region, 12/31/12

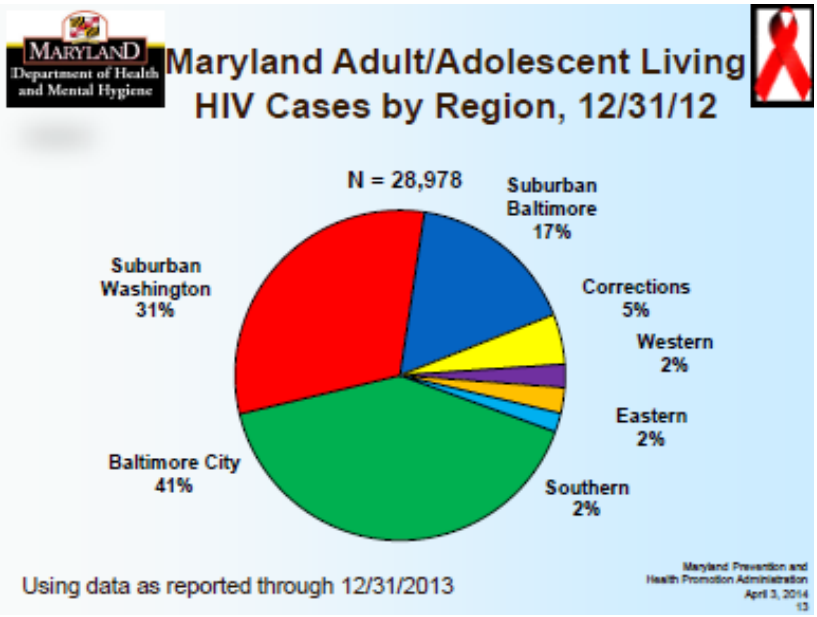
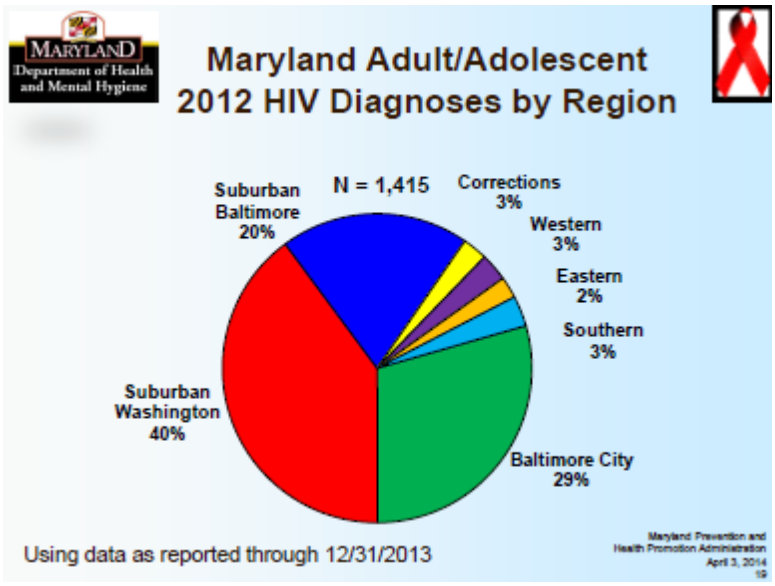


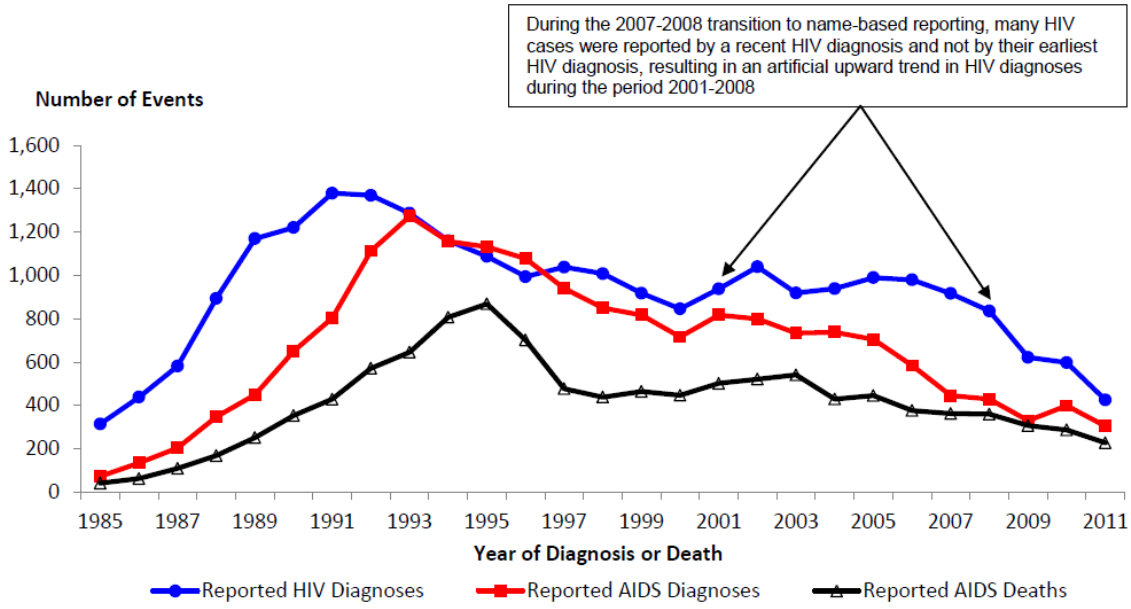
Figure 2: Maryland Adult/Adolescent Living HIV Cases by Region, 12/31/12



After the transition to name-based reporting in 2007, there was an artificial upward trend in reported HIV diagnoses for the time period of 2001 – 2008. However, rates of HIV and AIDS diagnoses and AIDS deaths have been steadily decreasing over the past several years. In 2011, there were a total of 12,072 individuals living with HIV in Baltimore, with 424 individuals

newly diagnosed, 5,333 individuals living with HIV without AIDS, and 6,739 individuals living with AIDS.

Figure 3: Trends in Reported HIV and AIDS Diagnoses and Deaths, 1985 - 2011

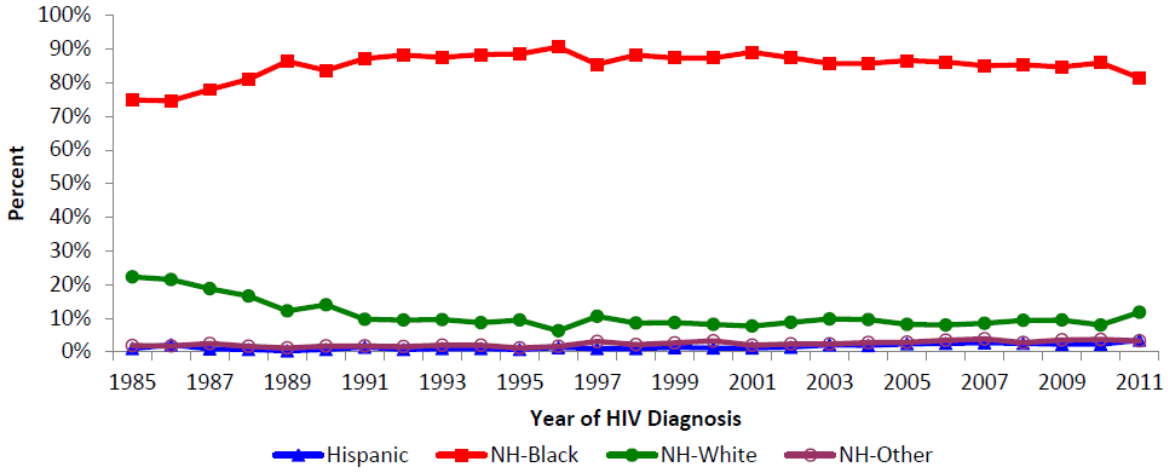


Demographic Information

Race

HIV continues to disproportionately impact African-American individuals. While African-Americans composed 62% of the population in Baltimore, in 2011 they composed 81.4% of new HIV diagnoses and 84.4% of living HIV cases. While the rates of HIV among African-Americans are disproportionately higher than other racial categories, the rates of new diagnoses slightly decreased from 86% in 2010 to 82% in 2011, while rates among Hispanics and Non-Hispanic Whites have increased (from 2.3 to 3.5% and 8.0 to 11.8% respectively).

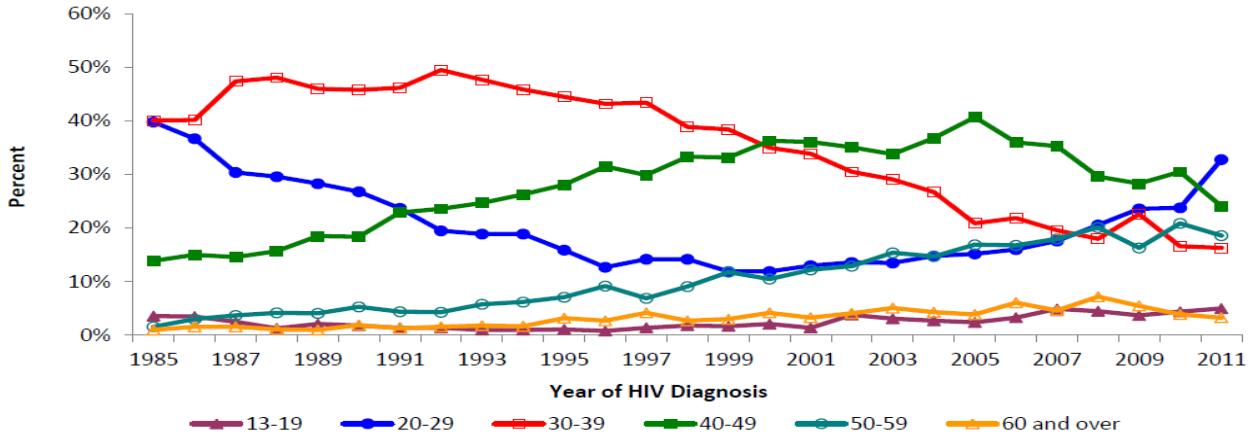
Figure 4: Trends in Adult/Adolescent Reported HIV Diagnoses by Race/Ethnicity 1985 – 2011



Age

The 20 – 29 year old age group had the greatest increase in new HIV diagnoses, accounting for 33% of new diagnoses; an increase from 24% in 2010 and 2009. Rates also increased among those aged 13 – 19 (from 4% in 2010 to 5% in 2011), and decreased among those aged 40 – 49 and 50 – 59 (from 31% to 24% and 21% to 19% respectively). While the rates are decreasing among those aged 40 – 59, it is important to note that those over the age of 40 account for 46% of new diagnoses.

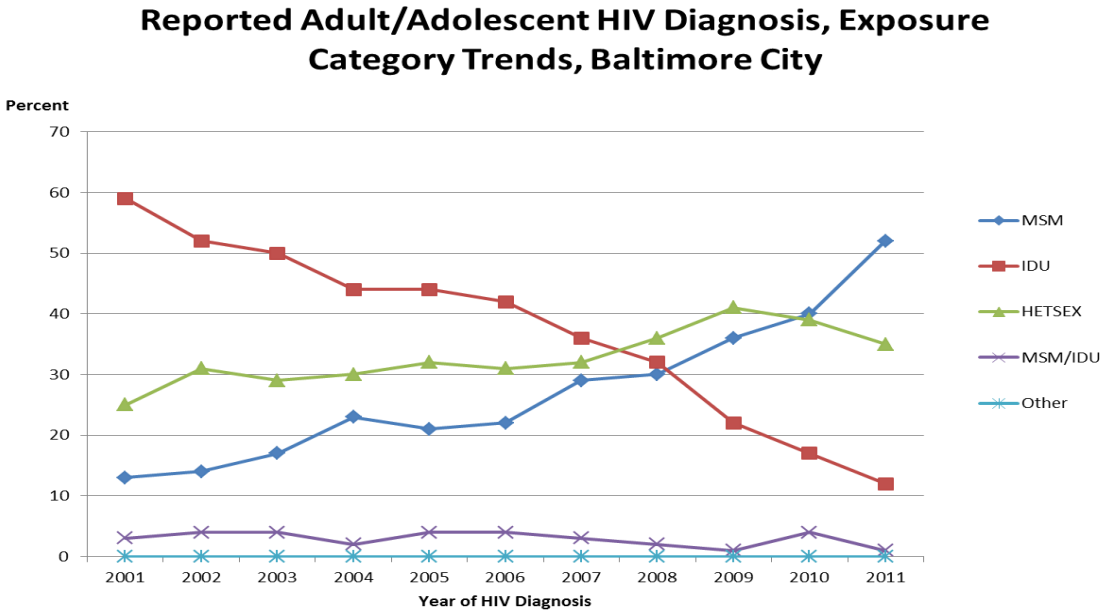
Figure 5: Trends in Adult/Adolescent Reported HIV Diagnoses by Age at Diagnosis, 1985 - 2001



Exposure Category

Rates of HIV have been increasing since 2007 among MSM, accounting for 52% of new diagnoses in 2011. By contrast, rates among injection drug users have been steadily decreasing with 12% of new diagnoses attributable to injection drug use. Rates of transmission from heterosexual exposure have been declining since 2009, accounting for 34.5% of new diagnoses. Rates among both MSM/IDU have remained low, accounting for 1.1% of new diagnoses.

Figure 6: Trends in Adult/Adolescent Reported HIV Diagnoses by Exposure Category, 1985 – 2011



Using data as reported through 12/31/2012

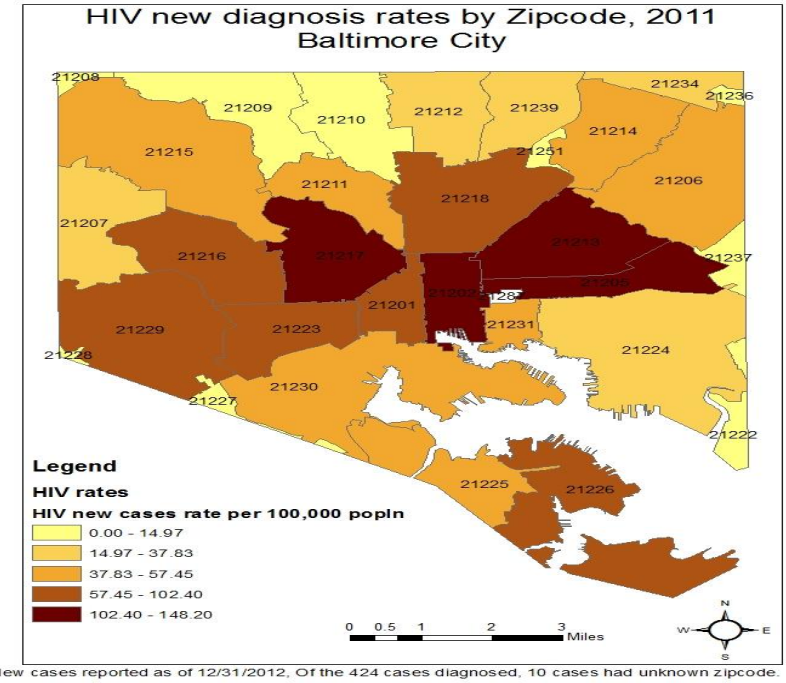
Area of Residence

There are several zip codes in the city that experience the greatest burden of HIV.

Table 2: Adult/Adolescent Living HIV Cases in High-Prevalence Zip Codes

Zip Code	# of Cases	% of Total	Rate	Ratio
21205	604	5.0%	4825.4	1 in 20
21217	1,388	11.5%	4,566.2	1 in 21
21202	825	6.8%	3,989.0	1 in 25
21223	801	6.6%	3,768.9	1 in 26
21201	553	4.6%	3,652.1	1 in 27

Figure 7: HIV New Diagnosis Rates by Zip code

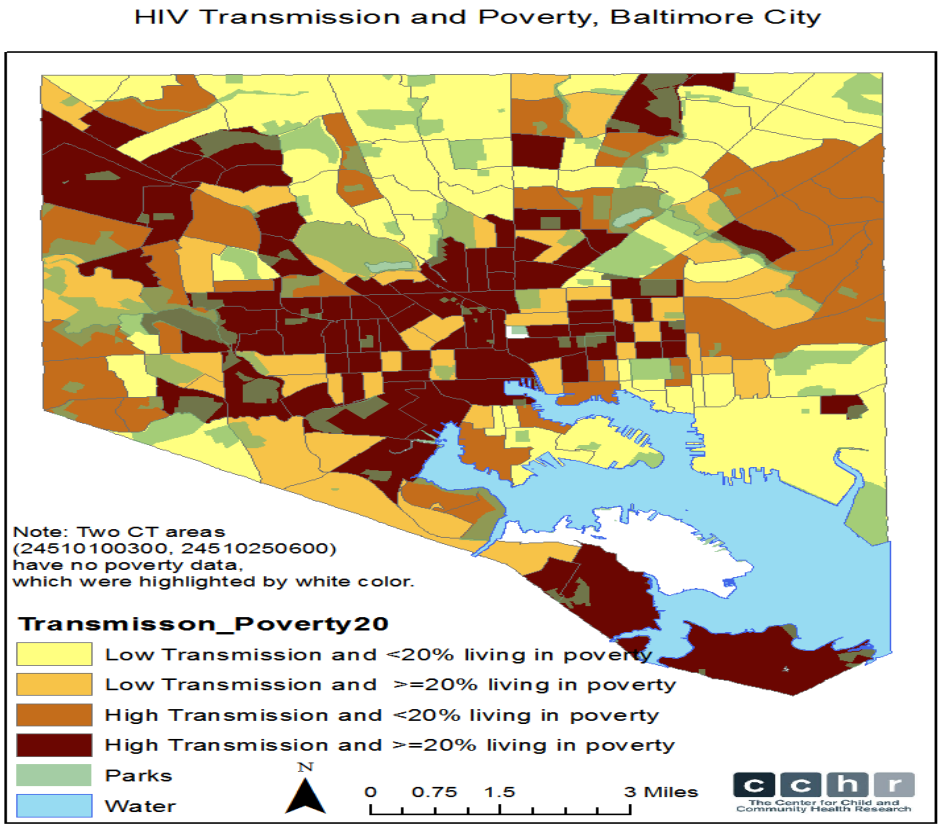


New cases reported as of 12/31/2012, Of the 424 cases diagnosed, 10 cases had unknown zipcode.

Socioeconomic Status

There is a correlation between socioeconomic status and HIV. In Baltimore, the greatest density of individuals living with HIV resides in areas where more than 20% of the population lives in poverty.

Figure 8: HIV Transmission and Poverty



Source: Baltimore City Health Department, Maryland Department of Health and Mental Hygiene, 2012 American Community Survey.

2.3 Co-morbidities: Syphilis and Injection Drug Use

A significant proportion of persons diagnosed with bacterial STIs in Baltimore are co-infected with HIV. Overall, of the 10,561 cases of Chlamydia, gonorrhea and early syphilis reported to the BCHD in 2011, 351 (3.3%) persons were co-infected with HIV. Persons at risk for early syphilis are also at substantial risk for acquiring HIV, as just over 162 (43%) of early syphilis cases reported in 2011 are HIV-positive. Because our numbers only represent documented HIV

infection (where the infection has been diagnosed and reported to the BCHD), these data likely underestimate the true prevalence of HIV co-infection among persons with reportable bacterial STIs throughout Baltimore. Nonetheless, our data indicate that there is a substantial burden of HIV infection among persons with incident STIs.

HIV Prevalence among Persons with Reported Early Syphilis
Baltimore, MD
January 1, 2011 – December 31, 2011

Early Syphilis	HIV Positive	HIV Negative/ Unknown	Proportion HIV positive
Males	157	159	49.68%
Females	5	53	8.62%
White, Non-Hispanic	18	17	51.4%
Black, Non-Hispanic	139	189	42.37
Other	5	4	55.5
TOTAL	162	212	43.3%

In 1994, it is estimated that approximately 650 incident cases of HIV in Baltimore were attributable to injection drug use, representing 60.3% of reported HIV diagnoses. In 1994, Governor Schaefer signed Baltimore City's needle and syringe exchange program into law. The program is operated by the Baltimore City Health Department and represents the only such program in the state. Sixteen years later after its inception, the number of new HIV infections attributable to injection drug use has dropped to 177 new cases per year, representing a 29.5% decrease in the proportion of new HIV diagnoses attributable to injection drug use. Baltimore specific data collected between September to December of 2009 for the National HIV/AIDS Behavioral Surveillance indicate that the HIV prevalence among injection drug users is 16.2%. Among clients of Baltimore City Health Department's Needle Exchange Program, the HIV prevalence is approximately 12.2%, a conservative estimate due to missing data.

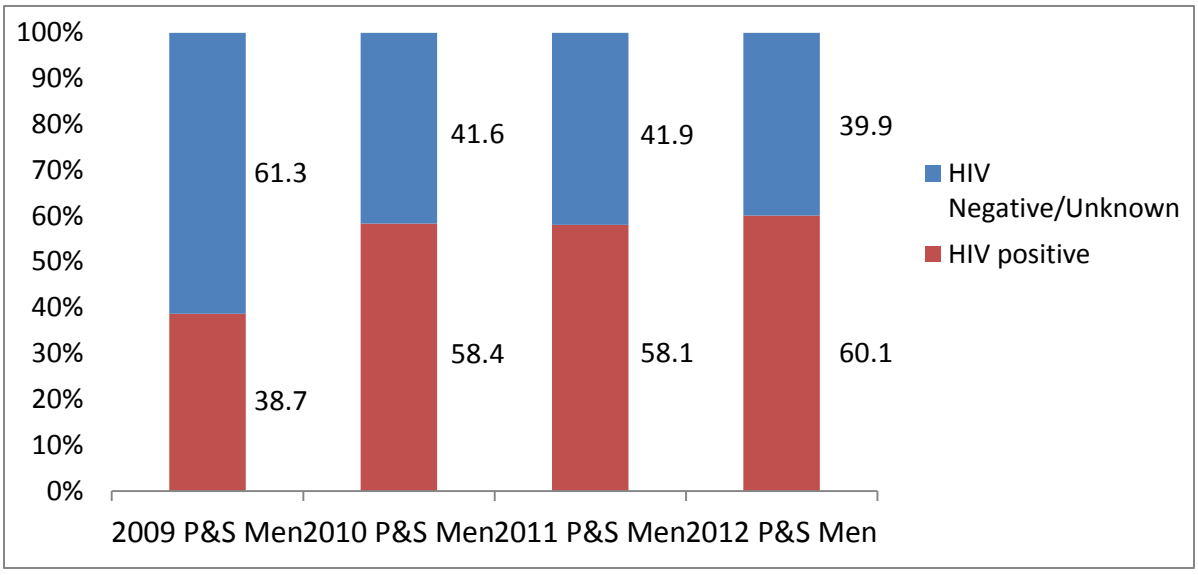
Despite these successes, the issues of substance abuse and HIV transmission as related to

injection drug users remains a serious public health challenge in Baltimore. Baltimore City continues to have a disproportionate number of injection drug users at risk for HIV and other communicable diseases. Scientific research continues to define and support the role syringe exchange plays in curtailing the HIV epidemic in vulnerable communities, therefore the Baltimore City Health Department's Needle Exchange Program plays a key role in the statewide Maryland HIV Prevention Plan, specifically in Baltimore City.

*HIV and Syphilis Co-Morbidity Update**

The co-morbidity of HIV and syphilis remains persistent, especially among males. The rates of males co-infected with HIV and syphilis have been increasing with 60% of the men who had syphilis in 2012 also being HIV-positive; an increase from 39% of men in 2009. Correspondingly, the rates of males with syphilis who were HIV-negative or HIV-unknown decreased from 61% in 2009 to 40% in 2011. The following chart shows the trends of primary and secondary syphilis and HIV co-infection among men from 2009 – 2012:

Figure 9: Primary and Secondary Syphilis and HIV Co-Infection Among Men, 2009 - 2012



2.4 Priority and Vulnerable Populations

MSM

As noted in Section 2.1, HIV transmission is highly concentrated among African-American MSM, a group that has been difficult to access. For the past 18 months, BCHD has committed to building relationships with members of this community. In early 2010, we conducted a number of focus groups with members of the MSM community, which led to collaboration with Baltimore's House Ball Community, a subgroup of the Lesbian, Gay, Bisexual and Transgender (LGBT) community. Many persons involved in the House Ball Community are young (many enter the scene as early as ages 12 or 13), feel marginalized and may engage in high-risk behaviors – one main source of income among the ballroom scene is escorting. In partnership with House Ball Community, we co-sponsored a "Know Your Status" Mini-Ball in November 2010. We tested 113 of the 500 attendees for HIV, 73 (65%) were 25 years old and younger, and identified 16 HIV infections (14%), 6 of which were new infections. Since young MSM in Baltimore are at high risk for both HIV and syphilis, we are planning similar events with this group and aim to expand to other groups throughout this project period.

Youths*

As adolescents and young adults have the highest rates of sexually transmitted diseases, BCHD has made it a priority to reach out to youths under the age of 25. In 2013, there were 22,186 HIV tests conducted among all age groups at Baltimore City's HIV outreach testing sites, and supported community health centers (CHCs), federally-qualified health centers (FQHCs) and community-based organization (CBOs) grantee sites, with a total of 549 HIV-positive tests. Out of all these tests, 5,403 (24.4%) were conducted on those less than 25 years of age. The following table shows the testing and positivity information for youths aged 13 – 19 and 20 – 29 from the Health Department's funded outreach testing sites, CHCs, FQHCs, and CBOs for 2013. This table does not represent all testing in Baltimore City for these age groups, but provides information regarding the testing efforts in the above areas.

	Population in Baltimore City[3]	Number of Tests Conducted in BCHD Outreach & in Supported CBOs, FQHCs & CHCs	Percent of Total Tests Conducted in BCHD Outreach & in Supported CBOs, FQHCs & CHCs	Number of Positive Tests from BCHD Outreach & in Supported CBOs, FQHCs & CHCs	Percent of Total Positive Tests from BCHD Outreach & in Supported CBOs, FQHCs & CHCs
Total Number of HIV Tests Ages 13 - 19	58,014[4]	1,927	8.7%	11	2.0%
Total Number of HIV Tests Ages 20 - 29	114,135	6,349	28.6%	115	20.9%

In order to engage this population, BCHD has established relationships with several organizations throughout the city to provide testing and counseling services to youths, including STAR TRACK, Harriet Lane, and Women Accepting Responsibility (WAR).

As part of its testing program, BCHD provides support, through direct funds, and/or providing testing kits, lab support, technical assistance, and monitoring and evaluation services to these agencies. STAR TRACK is an organization that provides health care, education, prevention, and support services to HIV-infected and at-risk youths, as well as training and education to professionals regarding prevention and care for infected and at-risk youths. Harriet Lane is Johns Hopkins child and adolescent health care clinic that provides care for youths who are infected with or affected by HIV, and WAR is an organization whose Knowledge is Power program specifically focuses on adolescents and provides a venue for HIV testing and prevention

[3] Source: United States Census Bureau. (2010). *Profile of general population and housing characteristics: 2010 demographic profile data.* Retrieved from: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

[4] Data from the U.S. Census Bureau was stratified by ages 10 – 14 and 15 – 19. Data for ages 13 and 14 was obtained by taking the population of 10 – 14, dividing by 5 to obtain the population for each age, and multiplying by 2 to obtain the population for ages 13 and 14.

activities.

BCHD also funds The After School Institute to conduct its annual Youth Sexual Health Conference (formerly the Baltimore HIV Prevention Youth Summit). Held every June, this event is designed to provide a forum for youths to discuss and receive information regarding sexual health through informative and interactive presentations regarding HIV/STD's, healthy relationships, dating violence, the effects of alcohol and other drugs, and LGBT issues. The conference also provides on-site HIV/STD counseling and testing.

BCHD's Youth Outreach Coordinator and Outreach team is instrumental in creating youth-specific testing events, including events specifically geared towards the LGBT-youth population. On August 17, 2013, BCHD held a picnic at Inner Harbor's Rash Field with music, food, HIV/STD resources, and testing. Earlier this summer, BCHD also held a pool party at Callow Hill Aquatic Center geared towards LGBT youth. For the past four years, the annual mini-balls have been a novel and innovative way of reaching the young MSM and transgender population. By sponsoring an event that fosters a relationship with this population and provides a house ball competition in addition to HIV/STD testing, the mini-balls have consistently tested approximately 100 people each year, has had positivity rates ranging from 11 – 17%, and new positivity rates ranging from 6 – 8%.

Heterosexuals*

Although rates of HIV among the heterosexual population in Baltimore have been declining, BCHD also aims to reach both high-risk and low-risk heterosexual individuals through our testing efforts. The efforts described below represent the Health Department's publicly funded HIV testing, but do not represent all testing in Baltimore City. In order to reach high-risk individuals, the BCHD Outreach team tests in high-HIV prevalence areas, five days and six nights a week, reaching those who may not present to a traditional testing facility, including commercial sex workers, IDUs, and those without stable housing. Also, the BCHD Needle Exchange program provides a means for high-risk individuals, regardless of sexual orientation, to obtain HIV/STD testing, establish a relationship with the health department and health care

system, and also receive risk reduction resources and wound care.

In addition to testing in high-prevalence areas, the Outreach team also tests at locations not necessarily geared to high-risk individuals. Annual events such as Artscape, and the African American festival (AFRAM), provides an opportunity to test those who may not be at high-risk for HIV, but at-risk nonetheless, include those who identify themselves as heterosexual. BCHD is currently exploring a partnership with the Baltimore City Department of Social Services (BCDSS) to conduct HIV testing in their assistance locations. In 2013, women only represented only about 42% of the clients who received HIV tests at outreach sites and community-based organizations, showing that there is an underrepresentation of women seeking out testing at traditional testing sites, including street-based locations, EDs and Community Health Centers (CHCs). Of the 11,020 recipients of the Temporary Cash Assistance program, (a BCDSS assistance program) in Baltimore in 2012, the majority of them were female (95%), young (62% less than 36 years of age), and unmarried (87%).[5] This partnership with BCDSS will provide a way to reach this underrepresented population in our testing strategies.

BCHD has also contracted with several hospitals in Baltimore to conduct HIV testing in either their Emergency Departments (EDs) or throughout the entire hospital (Bon Secours, Johns Hopkins, Mercy, Sinai, and University of Maryland Medical System). Testing in EDs and throughout hospital systems provides individuals who may not perceive themselves to be at risk for HIV access to testing services while seeking out another type of medical care. This access to testing has been expanded to include HIV testing at the University of Maryland School of Dentistry, and CHCs such as Park West and Total Health Care.

Through the Category C detailing project, Protect Baltimore, primary care providers are given support and guidance in establishing best practices in implementing routine HIV testing in their practice. Providing routine HIV testing via primary care providers allows those high- or low-risk individuals who would not present in other settings the ability to be tested for HIV during a routine physical, or visit for another medical issue.

[5] Gleason, E., Nicoli, L., Born, C.E. (2014). *Life on welfare: Trends in the 2012 TCA caseload.* Baltimore: University of Maryland.

3. Existing Resources and Services

3.1 Coordination between Prevention and Treatment

BCHD integrated all HIV services into the STD Prevention Program in 2004, thus integrating HIV testing, counseling, reporting, and partner services with STD testing, reporting, and partner services. Recent reviews of HIV and STD surveillance data revealed that we were missing opportunities to notify and test persons who may have been exposed to HIV by only focusing HIV partner services on persons newly diagnosed with HIV. In collaboration with DHMH, we decided to re-initiate partner services for HIV-positive persons diagnosed with gonorrhea or chlamydia at either of BCHD's STD Clinics (as part of syphilis control, all syphilis cases receive partner services). Since this new protocol was initiated in June 2011, three persons have been initiated for partner services interviews.

BCHD will continue to support integrated HIV, STD, and hepatitis screening in the BCHD STD Clinics. In addition, BCHD TB services were recently integrated into the STD clinic services at the Eastern Clinic. The clinic staff will continue providing both conventional and rapid HIV screening, STD, hepatitis, and TB screening to all clients. Rapid HIV screening targets clients who would be unlikely to return for their conventional HIV test results, although it is also available for all clients. Funds from this award will be used to cover laboratory costs for these expanded viral hepatitis-screening efforts, while integrated HIV, STD, and TB screening will be supported by funds from other sources. This initiative will increase the number of MSM, IDU and other high-risk persons who are provided with HIV, STDs and viral hepatitis services.

Although BCHD will continue encouraging EDs to promote and screen for STDs, other appropriate settings in which to integrate screening and testing for other STDs, viral hepatitis, and TB into the HIV screening programs supported by this award will be assessed. This assessment will be done through examination of local epidemiological data related to HIV, STD, viral hepatitis, and TB, as well as consultation with staff of HIV screening programs. Factors that will be considered include: high rates of co-infection among the populations served by the HIV screening program; availability of funds to support STD, viral hepatitis, and TB screening;

agency capacity to fully integrate additional screening efforts into the HIV screening program; and evidence of the ability to return test results and provide treatment (or linkage to treatment) for the additional diseases.

After reviewing provider reports, we approached Chase-Brexton Health Services, the private provider reporting the largest number of HIV infections, and have developed a collaborative relationship to ensure that their HIV patients receive appropriate care. Through continued collaboration, nearly all patients served by Chase-Brexton receive partner services, are linked to care and receive routine STD screenings. This collaboration has been especially beneficial in ensuring high-risk MSM have access to HIV care as Chase-Brexton is the largest health care provider among Baltimore's MSM community. We will continue our collaboration with Chase-Brexton and aim to build similar collaborations with other providers in Baltimore.

3.2 Testing Strategies

When primary and secondary syphilis cases increased by 135% between the first and second quarters of 2004, BCHD requested assistance from the Centers for Disease Control and Prevention (CDC). In October and November 2004, with CDC assistance, we offered syphilis screening in venues/neighborhoods at high-risk for syphilis transmission. During these field screenings, most people also wanted an HIV test, and we identified many new HIV cases. The syphilis epidemic is ongoing among young (aged 25 years and younger) African American MSM, and the BCHD has used syphilis epidemiology to help inform where to test for HIV. From September 2004 – November 2010, the Syphilis Elimination Program tested 52,587 clients for HIV, identifying 4,817 (9.2%) HIV-positive persons. Through screenings held in soup kitchens, homeless shelters, methadone programs, other sites frequented by disenfranchised persons, various festivals (e.g., Gay Pride, Black Gay Pride, and the African-American Heritage Festival), Emergency Departments, and through CBOs, we estimate that we have tested approximately 12% of Baltimore's adult population.

Testing efforts have reached many African-Americans in Baltimore, the main population targeted by prior CDC-funded (PS07-768) programs in Baltimore City. Between September 30,

2008 and September 29, 2010, 74% of the clients tested in the EDs self-identified as non-Hispanic African-Americans, compared to 21% who self-identified as non-Hispanic Whites, and 2% as Hispanics. In addition, 84% of the newly diagnosed persons in the EDs were non-Hispanic African-Americans. For the same period, 88% of the clients tested in the STD clinics self-identified as non-Hispanic African-Americans, compared to 6% who self-identified as non-Hispanic Whites, and 4% as Hispanics. Of those who were newly diagnosed in the STD clinics, 95% self-identified themselves as non-Hispanic African-American. The following table shows the testing demographics for the city EDs and clinics from September 30, 2008 through September 29, 2010:

Table 2 - Testing Demographics for Baltimore City EDs and Clinics, 9/30/08 – 9/29/10

	Total # of Clients	**% of Non-Hispanic African-Americans Tested**	**% of Non-Hispanic Whites Tested**	**% of Hispanics Tested**	**% of Non-Hispanic African-Americans Newly Dx'ed with HIV**
EDs	30,952	74%	21%	2%	84%
Clinics	14,119	89%	6%	4%	95%

In close collaboration with the Department of Health and Mental Hygiene (DHMH) HIV Surveillance Program and the Ryan White Part A Program, BCHD continues to collect data to determine whether those identified as HIV-positive are previously undiagnosed infections ("new positives"). Our algorithm for making this determination is provided in the linkage-to-care portion of this document.

In July 2008, modifications were made to the Maryland Statutes regarding HIV reporting and testing, which allowed health care providers in clinical settings to provide opt-out testing for their patients. In August 2008, the DHMH informed all providers in the state of the changes in the law and recommended that practitioners in all health care settings (e.g. hospitals, urgent care or emergency departments (EDs), inpatient services, community health centers and clinics, correctional healthcare facilities, and primary care settings) offer diagnostic HIV testing and HIV screening as part of routine clinical care for individuals ages 13 – 64.

These changes also allowed health care providers to document the client's consent in the patient's medical record rather than obtain a separate informed consent form. (Outreach testing in non-medical settings is still required to obtain separate informed consent.) The regulations require that any individual tested receive:

1. Counseling related to the tests that are being performed
2. Assurances that the test and results are confidential
3. Information related to HIV transmission.

This counseling can be delivered orally, in written form, or through the use of videos.
In 2010, combined testing programs operated and/or monitored by BCHD identified 283 new HIV infections. Though the final data for 2010 is not yet available, if the total number of newly identified HIV infections is similar to the number reported for 2009 (505), BCHD's programs will have identified more than 50% of new HIV infections in the City. Due to our success in finding previously undiagnosed infections, we will continue to expand and improve our testing programs. Throughout the project period, BCHD will promote the expansion of opt-out testing as part of its portfolio of policy initiatives. Currently BCHD supports HIV testing in both clinical and non-clinical settings. These settings include:

STD Clinics

Baltimore's two public STD clinics provide both rapid and conventional HIV testing. All clients seen in the BCHD STD Clinics receive opt-out testing. Information is not available on how broadly these recommendations are applied in the health care community as a whole.

Results for all rapid tests are provided to the client within 30 minutes, and persons testing positive immediately have a confirmatory serology drawn. All persons who receive conventional testing and confirmatory testing are counseled to return for their results. In 2010, 89% of HIV-positive persons identified in the STD Clinic received post-test counseling. Every effort is made to ensure that persons who test positive receive their results, receive partner services (if indicated), and are linked to primary care. When an HIV-positive patient does not return to collect his/her test results, a field record is created and assigned to a Disease Intervention Specialist (DIS) who attempts to find and provide services to the HIV-positive

patient.

BCHD has also successfully implemented routine rapid HIV testing and expanded conventional HIV, STD, hepatitis, and tuberculosis (TB) screening in two BCHD STD clinics in the Eastern and Druid Health Districts. While these STD clinics have historically provided conventional HIV testing under other funding sources, the funding opportunities mentioned above have enabled BCHD to enhance integration of HIV, STD, TB, and viral hepatitis screening services.

Outcomes for new HIV positive patients diagnoses at the Baltimore City STD Clinics from 2007 to 2011:

HIV Testing in STD Clinics: Outcomes for New Positives

Grant Year	Total New Positives	Percent Post-Test Counseled	Percent Linked to Care	Percent Referred to Partner Services
Year 1	115	100%	97%	100%
Year 2	110	100%	94%	100%
Year 3	98	100%	73%	100%
Year 4	102	98%	98%	98%

Emergency Departments

All of the currently funded testing programs in EDs (seven of the twelve EDs located in the City) have been fully implemented for over three years in high prevalence areas in Baltimore City. These EDs include Bon Secours Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins University Hospital, Mercy Hospital, Maryland General Hospital, University of Maryland Medical Center, and Sinai Hospital. EDs use rapid tests, so all persons receive their (preliminary if the rapid test is positive) results on site. Persons who test positive have confirmatory serology drawn and are given an appointment to receive their results. When they

return for their test results, they are post-test counseled, and if positive, offered linkage to primary care and referred for partner services. Field records are created for all HIV-positive persons, and DIS attempt to find and provide test results and offer HIV-related services to patients who do not return to learn their results. In 2010, 89% of HIV-positive persons identified in the EDs were post-test counseled.

ED HIV Testing 2007 - 2013
Testing Volume and Positivity Baltimore Emergency Departments*

Grant Year	Total Number of HIV Tests	Number Newly Identified HIV-Positive Clients	Percent Newly Identified HIV-Positive Clients
Year 1	5,066	56	0.5 - 1.5%
Year 2	14,958	68	0.4 - 1.0%
Year 3	18221	83	0.4 - 0.7%
Year 4	18,355	57	0.0 - 0.5%
Year 5	19095	48	0.0 – 0.4%
Year 6	17799	46	0.0 – 0.4%

* Range across all sites

Outreach Screening

The outreach screening program uses a slightly different HIV testing protocol. Because outreach staff typically do not return to the same site and the population tested is very transient, the Program has implemented a phone results line that patients can call to receive their test results. All patients are given an ”appointment” date two weeks after the day their blood was drawn for HIV testing when they can call in to receive their results. If a person tests positive, a field record is initiated prior to their call-in date, and every effort is made to notify the positive persons prior

to their HIV phone results date, so all positives are contacted immediately upon receipt of their results from the BDC laboratory. This allows us the opportunity to provide HIV positive results to clients in person. In addition, many of these clients are tested for syphilis and earlier case initiation allows us the opportunity to deliver syphilis and HIV related services at the same time.

Screening by Community Based Organizations

Most Community Based Organizations (CBOs) that use the Baltimore Disease Control Laboratory for their testing use the same phone-based results process as our Outreach services to notify patients of their HIV test results. Chase-Brexton Health Services, the largest provider of health services to the MSM community, uses the Maryland Public Health Laboratory. Services are provided in accordance with the procedures codified by DHMH. Since the Maryland Public Health Laboratory reports HIV-positive tests to DHMH rather than BCHD, we work with Chase-Brexton to ensure that all their HIV-positive patients are referred for partner services. In addition, if a client does not return for post-test counseling, they are referred to the BCHD for post-test counseling, partner services, and care linkage.

The following table shows the testing information for activities directly supported by BCHD, including the STD clinics, EDs, outreach testing sites, and CBOs for 2013:

HIV Testing Activities Directly Supported By BCHD CY 2013*

	Tested	Total HIV- Positive*		New HIV-Positive	
Site	**N**	**N**	**%**	**n**	**%**
STD Clinics	10741	123	1.14	66	0.61
EDs	17799	85	0.47	46	0.25
BCHD Outreach	12157	229	1.88	52	0.42
CBOs	5352	70	1.3	13	0.24
CHCs	7243	59	0.81	46	0.63
Total	53292	566	1.06	223	0.41

*Total HIV-positive includes persons newly and previously identified as HIV-positive

Other Healthcare Settings

BCHD's STD/HIV Prevention Program has extensive experience providing and supporting routine HIV screening in healthcare settings to increase the number of Baltimore City residents who know their HIV sero-status and are linked to HIV care, support, and prevention services, including prevention of new HIV infections. BCHD has worked closely with the DHMH since the start of the Expanded HIV Testing Program Initiative in 2007. Under the Centers for Disease Control and Prevention (CDC) PS10-10138 and PS07-768 funding opportunities, BCHD was funded by DHMH and has successfully implemented new routine HIV screening programs in multiple settings and healthcare facilities, including Emergency Departments (ED), STD (Sexually Transmitted Diseases) clinics, and other clinical settings located in high HIV prevalence areas.

Prenatal Care

In addition to health care and non-health care settings screening is conducted as part of prenatal care for pregnant women. Perinatal prevention will remain with DHMH in the first year of this funding cycle. Planning for BCHD's role in perinatal prevention programming will occur throughout 2012. We anticipate a shared responsibility with DHMH starting in 2013 and will complete a gap analysis together. Based on expertise and resources, we will divide functions to most efficiently fill gaps. For example, we will consider that part of perinatal prevention is educating providers. Since this is a requirement for the entire state, it may be most efficient for DHMH to maintain this function for Baltimore City, with input from the city in terms of content. Conversely, because of the strong relationship of the Program with obstetricians and infectious disease specialists as a result of congenital syphilis surveillance, more resources may be needed to expand the case management and follow up for women who are infected with HIV, similar to the model used for congenital syphilis. Women with congenital syphilis are up to six times more likely to be co-infected with HIV than those without a history of syphilis.

BCHD's two public STD Clinics offer HIV tests to all patients and provide pregnancy testing when indicated. In 2010, we tested 177/204 (86.8%) pregnant patients for HIV, two of whom were HIV-positive. All pregnant patients identified in our STD clinic are referred for prenatal

risk assessment by Baltimore Health Care Access, the city's quasi-governmental agency charged with helping link individuals to insurance and health care. Prenatal risk assessment may result in any of the following depending on a woman's need: enrollment in Medicaid, referral to home visiting program and linkage to prenatal care.

As part of the Partner Services interview process, DIS staff always asks HIV-infected patients if their sex partners or associates may be pregnant. All persons identified during DIS interviews are initiated for follow-up, and if found, are offered HIV testing and referred to prenatal care when indicated. Currently, a substantial number of new HIV infections are diagnosed among MSM, so HIV-positive patients infrequently identify sex partners or associates who may be pregnant.

"Do Not Test" List

BCHD routinely analyzes surveillance data to better focus outreach testing toward high-risk areas and populations in order to more efficiently identify newly infected persons. A recent review of surveillance data revealed that a number of persons previously identified as HIV-positive are requesting new HIV tests solely to receive the small incentive. To avoid repeat testing of these persons, we implemented a "Do Not Test" list. As a client registers for testing, his/her identifying information and HIV status is compared to our confidential morbidity database to assess whether that client previously tested HIV-positive. Since we started the "Do Not Test" list, we avoided testing 268 previously identified HIV-positive patients, linked 19 persons to care, and saved $12,060 in unnecessary confirmatory testing. We also use the location of syphilis incidence as a method to target screening, as Baltimore residents with a history of syphilis are up to six times more likely to be infected with HIV than those without a history of syphilis.

3.3 Category C Strategy: targeted testing utilizing new diagnoses*

Baltimore's HIV epidemic is characterized by marked and persistent differences in the distribution of rates of HIV/AIDS by high-risk behavior, geographic area and demographic group. This suggests the occurrence of multiple, localized epidemics or mini outbreaks throughout the city and underscores the need for targeted HIV control strategies. Targeted

control, which seeks to interrupt transmission from infected individuals to uninfected individuals by focusing on those most likely to transmit infection, has been used as an effective tool in the control of outbreaks for centuries. For HIV, evidence demonstrates that targeted control aimed at transmission is cost-effective. While our current outreach testing service utilizes a targeted approach, given the extent of Baltimore City's HIV burden and changing epidemiology, the Category C Innovative Demonstration Program Project seeks to utilize enhanced HIV surveillance data to refine targeted HIV testing.

The Category C Innovative Demonstration Program Project is a CDC funded initiative under Funding Opportunity Announcement, PS12-1201. The project is a collaborative four year program between the BCHD and the Center for Child and Community Health Research (CCHR) (Dir: Jacky Jennings, PhD, MPH) at Johns Hopkins School of Medicine. The program has three main goals:

1) Implement viral load testing of all confirmed HIV positives
2) Focus HIV outreach testing in high HIV transmission areas, i.e. "Hot Spots"
3) Ensure adoption of current HIV testing and treatment guidelines and increase awareness of services available for HIV positive patients among health care providers in Baltimore City.

The following represents a description of the activities related to achieving the three main goals of Category C including the individuals responsible and the progress and barriers toward the completion of the activities. Through these activities, we will increase HIV testing, the identification of positives, specifically those with recent infection, and the linkage-to-care of these positives. By doing so, we intend to reduce viral loads in high transmission areas and ultimately, reduce the number of new HIV infections in Baltimore City annually.

Objectives	Responsibility	Progress and Barriers
Obtain viral load data from the DHMH to supplement new viral load protocol	CCHR and BCHD leadership CCHR/BCHD Epidemiologist	Status: Complete
Develop protocols for geo-mapping of viral load and other surveillance data to identify high transmission areas	CCHR/BCHD Epidemiologist	Status: Complete
Develop, pilot, and revise HIV Testing Action Kit	Public health detailers CCHR/BCHD Epidemiologist	Status: Complete
Identify all primary care providers within high transmission areas	Public health detailers CCHR/BCHD Epidemiologist	Status: Complete • Contacted 999 providers in and around Baltimore City. o 49% (485/999) are current primary care providers with office locations within Baltimore City. ▪ 42% (202/485) of the 485 are located in high

		or very transmission areas
Implement viral load testing protocols for all confirmed HIV positives	CCHR/BCHD Epidemiologist BCHD Lab Maryland Department of Health and Mental Hygiene Lab	Status: Ongoing • October 2012 - April o 645 viral load tests (VL) conducted among confirmed HIV+ individuals ▪ 58% had low VL ▪ 35% had high VL (> 1500 copies/mL) ▪ 7% had very high VL (≥ 50,000 copies/mL)
Train and re-train Public Health Detailers on HIV Testing Action Kit delivery	CCHR/BCHD Epidemiologist	Status: Complete • 2.5 detailers trained successfully
Distribute, receive feedback, and update HIV Testing Action Kits	Public health detailers CCHR/BCHD Epidemiologist	Status: Ongoing • Phase I complete; Phase II in progress. • During Phase I: o Contacted 100% (n=85) of eligible primary care practices located in high transmission areas ▪ 95% (81/85) have at least one HIV testing action kit o Reached 76% (154/202) primary care providers in these practices. Primary care providers are defines as individuals able to order an HIV test (i.e., nurses, physicians, physician assistants) ▪ 100% of providers contacted accepted an HIV testing action kit. o 82% of clinic managers/physician clinic leaders have accepted a kit. o Multiple kits (n=75) have been accepted and

		requested by project partners and others that have learned about our project including Kaiser Permanente, Johns Hopkins Emergency Department, Generation Tomorrow, Maryland Department of Health and Mental Hygiene, JHU CFAR, GILEAD Sciences, Baltimore City HIV Planning Group, Amerigroup. o We have received additional funding from GILEAD Sciences as a result of the initial success of category C. The funds will enable us to provide intensive detailing to high volume practices.
Ongoing update of primary care provider lists	Public health detailers	Status: Ongoing
Visit primary care providers quarterly	Public health detailers	Status: Ongoing Phase II of the detailing campaign is currently in progress**.**
Use enhanced surveillance data to inform/change public health practice	CCHR and BCHD leadership	Status: Ongoing Detailing Campaign: • Used community Viral Load Maps used to identify primary care providers for focus of detailing campaign • Based on responses to interviews, detailers will provide support in the areas clinic managers and providers identify or reveal they are less confident in addressing (e.g. linkage to care). • We will have compiled a master list of needs providers have expressed and are identifying resources that can help address these needs. Viral Load Testing Protocol: • Using community viral load maps paired with GPS

		data regarding current BCHD mobile unit locations over time to inform future selection of mobile unit testing/screening sites • Using project QA/QC data to determine the cost effectiveness of processes such as viral load testing coupled with syphilis testing • Changed BCHD policy and created a new algorithm for enhanced triage and follow-up of high viral load patients
Collect Evaluation Metrics	CCHR/BCHD Epidemiologist Public health detailers	Status: Ongoing

3.4 Linkage to Care

According to Maryland law and BCHD HIV testing policies, all clients who are tested for HIV must be provided with post-test counseling that is tailored according to the result of their HIV test. For clients with HIV-positive test results, Maryland regulations specify that post-test counseling must include: "a review of information regarding transmission of HIV and means of preventing transmission of HIV from one individual to another, including: abstinence; safer sex techniques and use of condoms for all sexual encounters; never sharing hypodermic needles or other drug paraphernalia, and seeking treatment for a drug addiction problem; never donating blood, semen, tissue or breast milk; and implications of pregnancy."[6] BCHD will continue to provide training and technical assistance to HIV testers supported under this award to ensure that all HIV-positive persons receive client-centered prevention counseling in accordance with this law to reduce the transmission of HIV in Maryland. BCHD staff will monitor adherence to these requirements and the quality of prevention counseling.

All newly-identified HIV-positive clients and previously-diagnosed HIV-positive clients who are served by these screening programs will be linked to care through:

1. Direct linkage to an onsite infectious disease or HIV clinic
2. Active referral to an off-site HIV clinic affiliated with their institution
3. Active referral to BCHD STD clinics
4. Active referral to another HIV medical provider of the client's choice.

At the time of the initial rapid HIV test, the HIV tester will make a follow-up appointment with an HIV medical provider for clients that test preliminary positive. During that appointment, the client will receive the confirmatory result and will receive a same-day appointment with an HIV care provider, including same day transportation. In addition to providing partner services to HIV-positive clients, Disease Intervention Staff will assist participating healthcare settings with the provision of post-test counseling and linkage to care services when clients do not return for their confirmatory test result.

[6] 1 Code of Maryland Regulations, 10.16.08.10C, http://www.dsd.state.md.us/comar/comarhtml/10/10.18.08.10.htm

Under PS07-768 and PS10-10138, BCHD worked with HIV testing programs, our partner services program and HIV medical care providers to collaboratively develop a referral network to ensure linkage to HIV medical care. As mentioned earlier, 63% of newly diagnosed HIV-positive clients in EDs were linked to care (attendance of at least one medical care appointment) during the 9/30/2008 - 9/29/2010 period of the Expanded HIV Testing Program. We will continue to build on this network to increase the proportion of HIV-positive clients who are linked to HIV medical care, prevention, and support services on the same day or within 72 hours, depending on the type of service that is needed.

All the testing staff are trained and required to set up the first medical appointment at the first testing encounter for clients whose rapid test results in a preliminary positive. This appointment is often combined with the appointment to receive confirmatory test results. This enhances timely linkage to care and minimizes the number of appointments the client must keep with the providers, which can be a hindrance for some clients with conflicting schedule priorities. Furthermore, the testing staff are trained and required to request DIS assistance with field follow-up for clients who miss the first appointment without a sufficient reason. They are also trained and required to submit encounter forms after the first encounter. BCHD will continue to monitor the timeliness of linkage to care and encourage compliance.

The BCHD STD/HIV Prevention Program Linkage to Care team provides linkage to care services to clients who are referred to BCHD or encountered through the various testing activities. Same-day appointments are made for HIV care services, and the client is offered transportation to the first and second appointment. Even though these services are promoted to healthcare providers and are advertised in social media such as websites, Facebook, and fliers in order to reach priority and marginalized populations, potential still exists to improve awareness of these services to improve their utilization. BCHD will continue to enhance social marketing strategies and expand collaborations with local HIV care providers to increase the pool of providers.

Providers are required to link all persons diagnosed with HIV to medical care and care management services. In addition, all persons who are newly diagnosed with HIV infection are referred to the BCHD Surveillance Team for partner services. Some of the providers send their blood specimens to the BCHD laboratory, using the STD Screening Intake Form and BCHD Laboratory Test Requisition. All positive test results are processed through the BCHD's central office. The BCHD receives information on HIV positive diagnoses from the following four sources: the Baltimore City Health Department Laboratory, Counseling and Testing Projects supported by DHMH, private providers, and monthly reports to BCHD from DHMH HIV Surveillance report of positive cases of city residents. All reports are entered in STD/MIS within two business days.

The Program has offered linkage-to-care services since 2005, and has linked approximately 800 people to primary medical care and case management services. The focus of the Program's outreach linkage-to-care services is to link HIV-positive clients who are not enrolled in HIV primary care or who have fallen out of care for six months or longer. The Program also offers outreach services to other providers who are unable to contact their clients who have fallen out of care. The Program's linkage-to-care program is integrated with the BCHD Early Intervention Initiative (EII) and provides services throughout Baltimore City's high HIV-morbidity areas. The Program encounters a significant number of HIV-positive clients with multiple co-morbidities, and often encounters clients who have tested positive, repeatedly. The Care Linkage Investigators (CLI) and DIS make phone calls and field visits to find them for linkage-to-care and/or partner services. Occasionally, clients cannot be located despite repeated follow-up attempts. When clients are located, transportation services to first and second appointments are provided via cab vouchers or by a care linkage team member in the Program's mobile unit. As an incentive to keep first and second appointments, gift cards are given to clients after completing the second appointment.

The Program offers care linkage and transportation services to the following populations:

- Clients retested for HIV, who were previously diagnosed for HIV with unknown linkage-to-care status

- Clients who are newly diagnosed with HIV
- Clients with an HIV-positive test result who were classified as "unable to locate" through past field investigations
- Clients diagnosed as HIV-positive in the private sector with unknown linkage-to-care status or who are reported to have fallen out of care
- Clients diagnosed as HIV-positive from the six EDs funded through the BCHD Expanded Rapid Testing Program who do not return for their primary care appointments

Once an HIV-positive person is identified, the Program initiates its five-step assessment and linkage strategy to facilitate access to care. The Program's highest priority is the linkage-to-care needs of all newly-diagnosed persons and previously-diagnosed persons who are unaware of their HIV-positive status. The five-step assessment and linkage strategy includes:

1. The Program queries four separate databases (STD/MIS, Insight Clinic Management System, the Maryland HIV/AIDS Surveillance database, and a centralized Ryan White database of persons in care); to assess each HIV-positive person's current post-test counseling status and prior utilization of HIV care services. If a person cannot be found in any of these databases, the person is likely to be new to the system and may be in need of the full range of services, including post-test counseling, partner services, and linkage-to-care.
2. The Program prioritizes each HIV-positive client based on the following three criteria in descending order of importance: (a) knowledge of their HIV status, (b) prior access to HIV partner counseling and referral services, and (c) documentation of previous access to primary care.
3. New clients are assigned to DIS who conduct field visits to notify them of their test results, offer partner services, and assess their ability to access primary care services. The DIS discusses primary care options and assists in transporting the clients to Ryan White-funded primary care services.
4. Previously-identified HIV-positive clients are assigned to a CLI, who also conducts field visits to verify whether clients are enrolled in primary medical care. If the clients are not in care, the CLI will discuss primary care options and transport the client to their selected

primary medical care provider.

5. The investigation outcomes and interventions are documented in the STD-MIS database by the Community Programs and Projects Coordinator. The Program management team reviews this data to identify opportunities to increase the proportion of those linked to care.

The care linkage team works with the Program's HIV testing initiatives, including two BCHD STD clinics, six EDs, four CBOs, BCHD Risk Reduction Program, and street/venue-based outreach settings that use mobile testing units to locate hard-to-reach HIV-positive persons who are unaware of their status. Outreach testing services that yield most of the clients needing linkage-to-care services are conducted at virtually all hours of day and night, testing between 12,000 and 14,000 socially marginalized residents per year for HIV.

The Outreach Coordinator chooses HIV testing locations based on recently collected client data including demographics, risk factors, and information obtained through DIS interviews of persons with HIV and early syphilis. When the outreach staff identifies high-risk venues, it can conduct screening there immediately and return on a regular basis if new positives are identified. The Program conducts testing and identifies extensive numbers of HIV-positive people throughout high morbidity communities.

Clients are told about the Program's care linkage services at the time of testing. Medical providers are also aware of this service through collaborations and Memoranda of Understanding (MOU). Many of the medical providers offer same-day appointments. Medical providers notify the Program when clients fall out of care, and the Program then works to locate and re-link them to care. Outreach staff members rely on existing collaborative relationships with Ryan White providers to link clients to care. While these informal processes are not documented, the clients' provider appointments are documented. There is also coordinated oversight and funding through contractual relationships with CBOs to conduct HIV testing and counseling. In addition, the Program has coordinated complex HIV/STD prevention research and evaluation projects with The Johns Hopkins University and grant agreements with the Maryland Prevention and Health

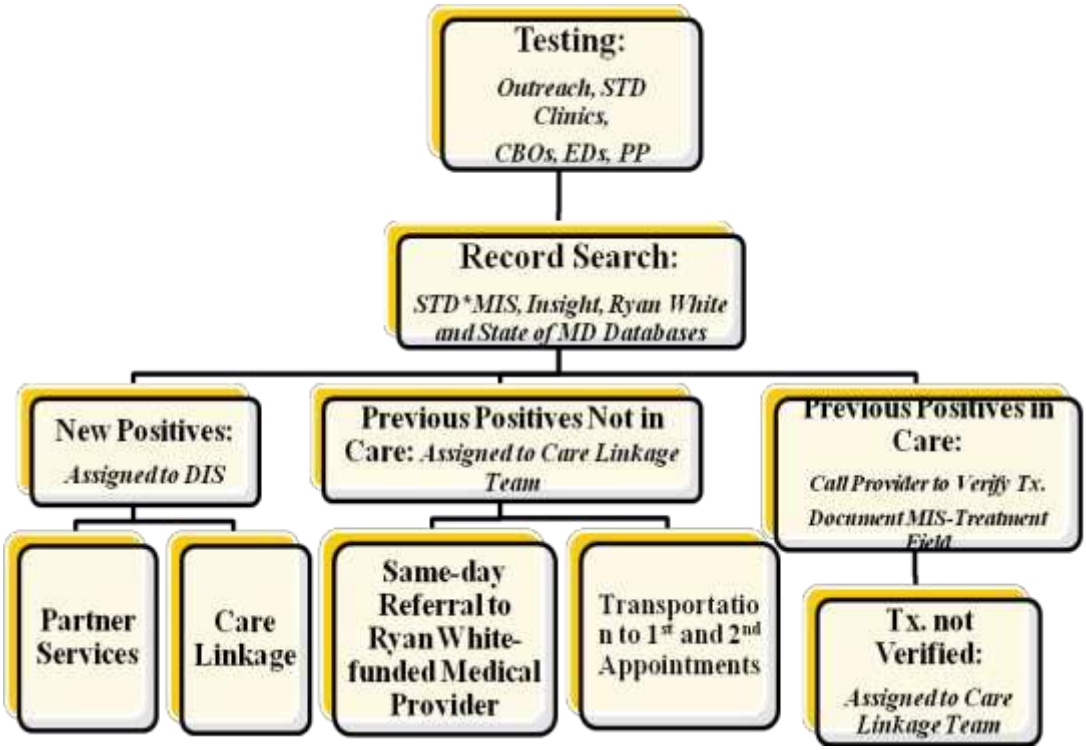
Promotion Administration. Through this experience and by providing partner counseling and referral services, the Program staff has extensive experience working collaboratively to overcome barriers and achieve positive outcomes for clients. This process is monitored formally through supervisory review of outreach staff performance, and informally through individual workers describing cases and brainstorming for solutions collectively.

The majority of clients linked to care are enrolled in the BCHD Bureau of Clinical Services HIV EII Program, which works closely with this Program. The EII Program operates within BCHD publicly owned clinics (Druid STD Clinic and Eastern STD Clinic). Clinic hours are Monday through Wednesday and Friday, 8:30AM-5:00PM, and Thursdays 8:30AM-1:00PM. STD walk-in services and HIV continuity services are available during all hours of operation. During times when staff is not available, clients have access to a 24-hour on-call service and a clinician where the client can be triaged for follow up of their medical concerns.

The Program's care linkage services are funded through Ryan White Part A Outreach Services, Ryan White Part A Minority AIDS Initiative (MAI), and Ryan White Part B MAI. The number of those linked to care under both Part A programs is reported to the BCHD Ryan White office monthly, using the Efforts to Outcomes (ETO) software. In addition, the Project Coordinator reports semi-annually to Ryan White all client-level data, which includes unique identification numbers and linkage-to-care outcomes. Finally, the Program submits five and seven-month work progress reports to the BCHD Ryan White team. For Part B, the Project Coordinator submits client tracking forms monthly, and quarterly progress reports to the Maryland Prevention and Health Promotion Administration.

.

HIV Care Linkage/Partner Services Algorithm



3.5 Care Retention

Since 1991, the Early Intervention Initiative (EII) Program has integrated medical and psychosocial continuity care to HIV-positive patients in underserved, low-income minority communities throughout Baltimore. With funding from Ryan White Parts A and B and Baltimore City General Funds, EII clinics employ clinicians, social workers, patient advocates, and other support staff to provide primary HIV care, diagnoses and treatment for STDs, cancer screenings (e.g. Papanicolaou tests), HIV counseling and testing, risk reduction counseling, and substance abuse counseling.

The EII Program provides a unique opportunity to instantly link, re-link and retain HIV-positive patients to HIV clinical services through:

- Co-location in STD clinics where patients at high-risk for HIV receive HIV and STD testing

- Flexible scheduling and same-day appointments
- Coordination with BCHD HIV prevention and linkage-to-care programs that provide HIV testing and linkage-to-care services throughout the city.

Linkage and retention in care are emphasized through:

- Monthly multidisciplinary rounds;
- Implementation of evidence-based interventions to increase linkage and retention in care including formal tracking of level of engagement in care, outreach, patient navigation, intensive case management and motivational interviewing.

The clinics accommodate both walk-in patients and appointments for follow-up visits. This flexibility helps ensure clients receive continuous care regardless of any changes to their daily routines.

The EII clinics also provide an antiretroviral treatment adherence program, including visits with a treatment adherence nurse and pillbox distribution and management. Directly Observed Therapy (DOT) programs also are made available upon clinician referral (BCHD and private clinicians). Clients referred to the DOT program receive five home visits per week (Monday – Friday) by a Client Advocate, who also may provide transportation to clinic appointments and assist with coordination of care.

Psychosocial services include individual psychotherapy, transportation support, emergency financial assistance for medications and nutritional supplements, client advocacy, and case management services. Furthermore, the Ryan White Emergency Financial Assistance and Transportation grants provide financial assistance for low-income persons who are unable to afford co-pays, who are in the process of obtaining prescription coverage, and who have transportation barriers. Case Managers provide referrals for substance abuse treatment, housing, and other psychosocial services not available directly through the EII Program.

The EII Program is housed within the BCHD STD clinics, both of which are easily accessible by

public transportation and located in areas with at-risk populations. Clinicians have experience working with high-risk, marginalized communities, and all employees (clinician and non-clinicians) are trained to be non-judgmental when assessing patients' risk behaviors and receive sensitivity training from a representative of the LGBT community.

The City STD clinics provide care to roughly 14,000 clients each year, of which about 3% are HIV positive. In 2009, a retention protocol was implemented consisting of phone calls followed by letters to reschedule missed appointments. In 2010, one full-time and one part-time outreach worker were hired to conduct street outreach and provide patient navigation services to patients linking or lost to care. Demographic information, diagnostic test results, and treatments of all patients seen for STD walk-in services and HIV care are documented in the electronic medical record. Data from 1/1/08 through 12/31/11 (N= 779 HIV+ patients) including demographics, test results, visit dates, treatment and HIV viral load were obtained and analyzed.

Statistically significant improvements over this time period was observed in: suppressed viral load; improved CDC4 cell count; retention in care; and percent on ART therapy. BCHD EII Program's evidence-based approach to linkage and retention in care demonstrates that STD clinics serving patients at high risk for HIV and non-engagement in care can successfully enroll patients in comprehensive HIV care and achieve high rates of care retention and suppressed HIV viral load. Following implementation of the retention protocol, the BCHD EII Program has increased the number of HIV+ patients engaged in care, initiated on antiretroviral therapy and who achieved a suppressed HIV viral load.

3.6 Partner Services

BCHD provides the following partner services to all HIV positive clients, including:

1. All clients with newly diagnosed HIV;
2. Previously HIV diagnosed clients with new syphilis infections; and
3. Previously diagnosed clients who attend a BCHD STD Clinic with new gonorrhea or chlamydia infections.

New HIV positive clients are identified through BCHD outreach testing, patients seen at STD

clinics, emergency room testing, CBO testing and reports from health care providers. Record searches are performed utilizing STD/MIS, INSIGHT, HARS and the City's Ryan White database. If no record is found in any of these management information systems they are considered new infections and assigned to DIS for partner services and referral to care. The attached Partner Services Protocol describes the procedure for partner services.

All staff conducting HIV testing under this grant will be trained on the importance of actively referring HIV-positive clients to partner services for identification, notification, counseling, and testing of sexual and drug injection partners. Through implementation of clear referral procedures and the provision of technical assistance, all HIV-positive clients will be counseled on the importance of notifying their partners during post-test counseling and actively referred to partner services. BCHD will support the DIS staff to ensure that all persons identified as HIV positive through these screening efforts receive timely partner services follow-up.

All grant-funded ED rapid testing programs will be required to report all HIV-positive clients to BCHD upon receipt of a preliminary positive test result using the HIV Case Report & Partner Services Referral Form. After the confirmatory test results have been delivered, the testing site will notify BCHD to proceed with contacting the client for partner services. If the client does not return for his/her confirmatory appointment, BCHD staff will already have the client's locating information from the *Referral Form,* allowing them to quickly initiate field follow-up for the delivery of the confirmatory result and the provision of partner services and linkage to HIV medical care.

Since DIS staff reside in both STD clinics, clients who have preliminary positive results on the rapid test are seen by DIS staff on the same day for partner services. DIS staff follows up with the client when they return for their confirmatory test results. For those who have conventional testing, the BDC lab runs confirmatory testing (Western Blot) on all specimens that are reactive on the ELISA test, hence the client receives partner services when they return for their confirmatory results. If the client does not return for his/her results, the DIS assigned to the client initiates a field follow up. The STD clinic staff and DIS utilizes an electronic medical record

(INSIGHT) for documentation. DIS also input their field record documentations in the STDMIS database.

3.7 Condom Distribution

While Maryland has no laws pertaining to condom distribution, BCHD has several strategies to provide condoms to high-risk persons. The Needle Exchange Program (NEP) provides condoms to all of its clients when they are seen. In 2010, NEP provided 80,000 condoms to intravenous drug users receiving services from the NEP van. The Outreach Testing Program offers HIV and syphilis testing to more than 60,000 people annually, and offers free condoms to all persons regardless of whether or not those persons consent to HIV or syphilis testing. One program goal for this funding cycle is to further expand our condom distribution program.
Through our outreach services, we encounter and distribute condoms to a number of persons at high-risk for HIV, including MSM, commercial sex workers, and IDU. As current epidemiologic data show that African-American MSM are at increased risk for HIV, we will provide condoms high-risk locations identified through MSM focused outreach. We will continue to use epidemiologic data to identify locations for condom distribution.

BCHD conducts over 100 HIV/STD Prevention presentations annually to schools, CBOs, faith-based organizations, state and local governmental agencies, health agencies, and others, reaching more than 4,000 people per year. The Community Health Liaison (CHL) is responsible for presenting and distributing condoms to these groups. From January – August 2011, we distributed 13,400 male and female condoms. The CHL also notifies qualified organizations about DHMH's condom and HIV/AIDS prevention materials distribution guidelines. In addition, thousands of condoms are distributed at both of our STD Clinics.

Measurement of condom distribution outcomes is challenging, because the ultimate measurement is condom usage, which is difficult to ascertain. We will monitor condom uptake by site and shift condom resources to sites and activities that frequently report running out of condoms. In addition, BCHD STD clinic physicians ask all patients about condom usage at last sexual encounter and frequency of condom usage (Always, Sometimes, Often or Never). We will

monitor these responses semi-annually and look for correlations with increase in condom use and distribution. We also will consider adding a reminder to the STD clinic risk assessment to track and assess condom distribution by physicians to clients.

3.8 Needle Exchange

BHCD's Needle Exchange Program (NEP) is the only confidential needle exchange program in the United States. This program provides BCHD with a unique opportunity to integrate HIV/STD testing services with harm reduction. Recently, a CDC-assigned Public Health Prevention Specialist (PHPS) reviewed HIV counseling and testing data from STD/MIS (BCHD's STD morbidity database) among NEP clients. The PHPS found that 51% of NEP clients have no record of being tested for HIV or syphilis in STD/MIS. To rectify this, we are coordinating our outreach services with NEP services, and our outreach team will offer HIV testing to all clients of the NEP mobile van. This intervention is especially important given that 14.5% of NEP clients who are tested are HIV-positive.

3.9 Policy Initiatives*

BCHD has focused on two policy initiatives during 2012 and 2013: the development of a confidentiality policy, which will allow for data sharing, and the pursuit of a distribution model for needle exchange. In 2014, our policy initiative focuses on the reduction of perinatal transmission of HIV.

<u>Confidentiality</u>

In 2013, BCHD successfully adopted and implemented National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) data security and confidentiality guidelines. We also conducted the required annual training for all BCHD HIV/STD Prevention Program employees, had walls and doors with simplex locks installed to establish physical security, data security, and confidentiality in our work area, and completed a new training module incorporating all data security and confidentiality changes for all employees.

Needle Exchange

The current NEP legislation requires a one for one exchange for needles - if one brings 10 needles, one receives 10 in return. In accordance with other needle exchange program, BCHD has been pursuing legislation to move from a one-for-one exchange to a needs based model that allows NEP clients to ask for up to 50 needles at a time, ensuring that clients are more likely to have access to clean needles. This bill passed during the 2014 General Assembly Legislative Session and will become effective October 1, 2014. See Appendix A in Section 7 for the memo on the implementation of the syringe exchange legislation.

Perinatal Transmission

Perinatal transmission of HIV is still occurring in Baltimore City. While current national data for perinatal transmission is hard to obtain, in the United States in 2009 there were 9.9 per 100,000 perinatal transmissions among African-American women. In Baltimore, there were 5,740 births to African-American women in 2011, and the rate of perinatal HIV transmissions were 34 per 100,000 live births. To address this issue, we have convened a team of stakeholders from DHMH HIV Surveillance and Prevention, DHMH STD, BCHD Maternal and Child Health, and BCHD STD/HIV Prevention Program. We are reviewing opportunities to improve the systems that will prevent perinatal transmission, as well as possibly develop legislation to implement a requirement or recommendation for third trimester testing for HIV.

3.10 Evidence-Based Interventions*

In 2012, BCHD funded several evidence-based HIV prevention interventions for high-risk negative individuals. These interventions were conducted at 7 organizations throughout the city, including:

- The After School Institute
- AIDS Action Baltimore
- Glenwood Life Counseling Center
- Health Care for the Homeless
- LIGHT Health and Wellness

- Sisters Together and Reaching
- The Portal/Empowering New Concepts, and served 610 clients.

These prevention interventions consisted of after-school HIV prevention initiatives, HIV prevention with transgender individuals, men who have sex with men (MSM), substance users, high-risk women, and African-American and Latino/a heterosexual men and women.

In 2013, BCHD's evidence-based intervention efforts have changed from prevention for high-risk negative individuals to identifying persons unaware of their status and further addressing prevention with positive individuals. The following organizations were funded to conduct evidence-based prevention with positives programs:

- LIGHT Health and Wellness – a group-level intervention to HIV-positive MSM in Baltimore City, particularly African American men
- Health Care for the Homeless – an individual-level counseling intervention for homeless HIV-positive persons
- Hope Springs – provides retention to care services for HIV-positive individuals identified from our grantees and the BCHD clinics through its Live Well [with HIV] Project

Currently, BCHD is continuing to fund evidence-based HIV prevention interventions for both positive and high-risk negative individuals:

- AIDS Action Baltimore – TEA (Transpeople Empowerment in Action) Time Program – group and individual level intervention focused on positive and negative transgendered individuals at high risk for obtaining or transmitting HIV
- Hope Springs, LIGHT Health and Wellness, and Health Care for the Homeless are continuing their interventions from 2013.
- On July 24 and July 25, 2014, BHCD coordinated a Personalized Cognitive Counseling (PCC) intervention for its grantees.
    - PCC is an individual level counseling intervention shown to have positive effects on increasing desired risk-reduction behaviors.

- This particular PCC training is designed to reduce unprotected anal intercourse among positive or negative MSM who are repeat testers for HIV and have had high-risk unprotected anal intercourse since their last HIV test.
- Representatives from 13 testing sites across the city registered for this training.

3.11. Social Marketing*

For at least the last six or seven years, we have seen an increasing and alarming concentration of the incidence of syphilis and HIV in the African-American MSM community, especially those under the age of 30 years. Despite our best efforts, we were having little success at reaching this population for testing or prevention. Through our social marketing campaigns, we aim to reach this at-risk population.

Campaigns

Testing Makes US Stronger

BCHD collaborated with CDC to launch the campaign in Baltimore about two years ago, and have recently promoted this campaign on August 17, 2013 at a BCHD-sponsored LGBT cookout at Baltimore Inner Harbor's Rash Field. The cookout was well-attended youths with lots of music, food, HIV and STD resources, and testing, and the Testing Makes Us Stronger staff had a booth at the events and provided resource information. The campaign also partnered with BCHD at the fourth annual "Know Your Status" Mini-Ball, and contributed to the cost of the photographer, disc jockey, and one commentator. The campaign also provided its backdrop to be used for photographs.

The "Know Your Status" Mini-Ball

Due to the elevated incidence of HIV and syphilis in the young African-American MSM community, we believed that we had to do more locally than we have typically done to engage this community. In the summer prior to our first Mini-Ball, we had a meeting with many of the House Parents in the House Ball Community. The House Ball community is an underground LGBT subculture in the United States in which "houses" "walk" (i.e. compete) for trophies and

prizes at events known as balls. In 2009, BCHD was influential in creating the House Ballroom Coalition. This coalition is comprised of leaders from each of the various houses in the Baltimore area. During that time, the Coalition was instrumental in planning the annual "Know Your Status" Mini-Ball, Status Update events, promotions, and other scheduled events in the LGBT community.

Currently, there are 8-10 houses represented in the Coalition, with 20 active members. In 2013, the Coalition met with BCHD staff about once a month, and BCHD is working with the Coalition to develop its structure and leadership skills, with the hope that it will eventually become a 501(c) (3) organization. This would allow it to apply for grants that can support it to plan different activities and community events.

In 2010, the first annual "Know Your Status" Mini-Ball was held. As an event designed to provide testing services to the young MSM community, there were 107 individuals tested with 16 testing positive and 5 newly positive. On November 16, 2013, BCHD hosted its fourth annual "Know Your Status Mini-Ball." This event was well attended, with over 600 youth in attendance, and nearly 100 people were tested. Our data show that 85 people were tested for both HIV and syphilis and five people tested for syphilis only. It also revealed 16 persons as HIV-positive, including both previous and new infections. These statistics are not only alarming, but also proof that additional prevention efforts need to be implemented within the LGBT community. It also shows that social marketing campaigns and non-traditional venues are a must if we want to combat HIV and other STDs within this community. The chart below shows the testing data for all four mini-balls from 2010 – 2013:

The Baltimore Status Update Campaign

In 2010, BCHD also learned of a Social Marketing Class at the Maryland Institute, College of Art (MICA) that would develop a marketing strategy as part of their class work for $15,000. We got far more than our money's worth from this effort. In order to adequately prepare for their social marketing campaign, the students of MICA conducted research and focus groups with

members of the community, attended events, and immersed themselves in the House Ball culture. After much focus group work, we developed the Baltimore Status Update campaign.

In partnership with MICA, we developed a website (baltimorestatusupdate.com) that focuses on the LGBT community and provides information on HIV and STDs, HIV, and STD testing locations, condom distribution sites, upcoming events, and different activities happening within the community. After working with MICA, we later hired a person to work as web manager for 20 hours per week. This person did not have a successful tenure as web manager. At the same time, our domain name lapsed and the website was non-operational for a short time. We have subsequently contracted with a nonprofit, Sexual Health Innovations, which took over responsibility for re-energizing and modifying the website. Sexual Health Innovations is updating the site and will be able to keep the information fresh and more attractive to the target population.

In 2013, BCHD continued its Baltimore Status Update website (Baltimorestatusupdate.com). We also obtained two Facebook accounts, which the community uses to access different resources and find different events happening within the city (Baltimore City Health Department STD & HIV Prevention https://www.facebook.com/pages/Baltimore-City-Health-Department-STD-HIV-Prevention/188728257827678 and Status Update https://www.facebook.com/baltimorestatusupdate).

The Baltimore Status Update campaign also consists of the bus ad campaign "Have Balls, Get Tested". We created a poster campaign featuring recognizable members of the local Ball community encouraging our target population of MSM, as well as other risk groups, to get tested and "know your status." These campaigns are double entendres specific to the community (e.g. "know your status" is knowing your status in the Ball community as well as knowing your HIV status.

In May 2013, we placed the "Have Balls, Get Tested" posters on the back of the free city-operated, Charm City Circulator shuttle buses that travel throughout downtown Baltimore. Our

advertisement ran for six months on the back of the Circulator and also on the video monitor inside the buses. We have been able to get some estimates of exposure to the campaign from the company that has the contract for putting the ads on the buses. In the 2013 advertisement period, we had in excess of 350,000 exposures each month for the six-month duration of the project. The resources for evaluation beyond exposures have not been available due to the intensity required to do such an evaluation and the cost involved. We currently have these advertisements on the buses again in 2014.

3.12 Monitoring and Evaluation

Major Data Sources

The program uses panoplies of data to inform programming. Currently, we use syphilis incidence to target outreach screening, which has been a good indicator for new HIV transmission in Baltimore. We also use geo-mapping of HIV and syphilis incidence to assess our testing coverage and resource allocation for outreach services. As of the writing of this document, we are implementing the viral load testing component of our Category C. Project. This data will further enhance our efforts to target our outreach testing as effectively as possible.

The program uses surveillance data from PHPA for a broad perspective on disease trends over time. Partner Services data provides real-time information on disease transmission. It also provides larger perspectives such as data on the number of newly identified HIV cases who named persons who were already positive as partners.

Continuous Quality Improvement Process

The program plans to continually improve the quality of data used for decision-making by program management and the HIV planning group. For example, all contracts with providers have specific outcome expectations. These outcome expectations are then incorporated into management reports. These reports are presented and reviewed at the monthly CQI meetings. For example, with testing reports, since all data is put into STD/MIS we can easily track each testing

contractors' progress on a monthly basis. When performance is behind expectations, the contractor is contacted and barriers to performance are problem-solved and overcome. This same data will be aggregated and will be provided to the HIV Planning Group at each of their meetings. This will allow them to compare the effectiveness, for example, of outreach testing, versus emergency department versus STD Clinic HIV testing.

4. The Baltimore City HIV Planning Group and Commission*

Once BCHD began receiving its funds directly from the CDC in 2012, we began the development of our first HIV Planning Group. Historically, the City had a Mayor's Office-mandated and appointed Baltimore City Commission on HIV/AIDS. The Commission was entrusted with designing, developing, and providing leadership in developing a strategic plan for addressing HIV/AIDS issues, and also providing policy guidance, recommendations, and consultation on efficient and effective HIV prevention and treatment interventions. Since the purpose of the Commission was similar to that of the CDC HIV Planning Group, Baltimore opted to dissolve the old Commission in Fall 2012, allowing for the development of a new group that would adapt the Commission's format and functions, but serve both as the jurisdiction's HIV Planning Group and the Mayor's-mandated Commission. The new, repurposed group was renamed the Baltimore City HIV Planning Group and Commission (HPG).

During the process of engaging stakeholders to serve as HPG members, the goal was to reach out to those directly involved in the continuum of HIV care, including those living with HIV, involved in the prevention and treatment of HIV, and able to aid in the implementation, monitoring, and updating of the Jurisdictional Plan. The announcement of the HPG and application information was released on July 12, 2013, and was sent to key stakeholders throughout the city, including providers, clients, House Ball Coalition members, and local universities, and it was also posted on the BCHD website and various local list-serves.

The applications were reviewed, and 26 individuals were selected to be approved by the Commissioner of Health and the Mayor of Baltimore to serve on the HPG. These individuals are crucial in providing HIV prevention, treatment, and care services throughout the city, and include

those living with HIV, representatives from community-based organizations, business, faith, and recovery communities, charitable foundations, universities, and the corrections system. In addition, the following stakeholders have appointed representatives to serve as ex-officio members on the HPG:

- State Secretary of Health
- State HIV/AIDS Administration
- Health Commissioner
- Health Department
- City Council President
- Department of Social Services
- Department of Housing
- City School Board Commissioner

The HPG had its first meeting on November 22, 2013, and was attended by 30 voting and ex-officio members. At this meeting, the National Minority AIDS Council (NMAC) provided orientation to the HPG, as adapted from what was presented at the HPG "boot camps," a series of CDC regional HIV planning trainings to address critical issues that are at the foundation of HIV planning efforts. An epidemiological overview of the state of HIV in Baltimore was also presented, and the HPG's role in the implementation, monitoring, and updating of the Jurisdictional Plan was also reviewed and discussed.

Following the orientation meeting in November 2013, the HPG has met several times in 2014. The focus of these meetings has included the following:

- Ratifying the HPG bylaws
- Electing a HPG Community Co-Chair
- Reviewing the Jurisdictional Plan
- Voting on the letter of concurrence for the Jurisdictional Plan
- Developing workgroups composed of HPG members and community stakeholders designed to strategically and systematically work on HIV prevention issues.

The HPG has formed several workgroups as a means to address current issues in HIV prevention, as well as the gaps and barriers listed in the Jurisdictional Plan. The current HPG workgroups include (as of July 2014):

- Billing and Reimbursement workgroup – created to work on the issue of billing and reimbursement for HIV testing
- Bylaw workgroup – created to implement the bylaws of the HPG and serve as a body of knowledge for questions or issues regarding the bylaws
- Corrections workgroup – composed of members of the Department of Public Safety and Correctional Services (DPSCS), the BCHD, and the Department of Health and Mental Hygiene (DHMH). The Corrections workgroup was created to coordinate and streamline the roles of DPSCS, BCHD, and DHMH in the correctional facilities in order to best address HIV prevention in the correctional facilities.
- Faith-based workgroup –created to rally the faith-based community in HIV prevention issues.
- Jurisdictional Plan workgroup – created to work with BCHD and the HPG-at-large on the implementing, monitoring, and updating of the Jurisdictional Plan
- PrEP – designed to create best practices regarding the implementation of PrEP as a HIV prevention measure in Baltimore
- Social media – created to disseminate HIV prevention messages and events via social media. One member of the HPG is a local newscaster and has already featured several news segments geared towards HIV prevention on the nightly news
- Youth – created to engage the youth population in HIV prevention.

5. Needs, Gaps and Challenges to HIV Prevention Services

5.1 Information System Infrastructure

While the efficiency and effectiveness of Baltimore City's Information system infrastructure has improved substantially, additional improvements will be required to meet the demand of an integrated STD/HIV prevention and care system. A table of the software packages used by STD/HIV Prevention and DHMH is provided below:

Software	Users	Vintage	Comments
Insight	STD Clinics/Needle Exchange	2003 with semiannual updates	Not compatible with STD/MIS
STD/MIS	STD/HIV Prevention, STD Surveillance, Care linkage, partner services	Circa 1990	No updates in several years, current plan at CDC STD is to stop supporting the software in the near future.
STD/MIS DHMH Version	STD programs statewide	Circa 1990	Same as above, DHMH does not use this software for care linkage. It is not linked to city system.
BDC Laboratory Information management system	STD Clinics, Family Planning, STD/HIV Prevention	Circa 1993	Electronic export only to STD Clinics, paper entry for all other tests and test results.
ETO software	Ryan White program STD/ HIV Linkage to Care and Partner Services	Within the last 5 years	Does not interface with any other software.

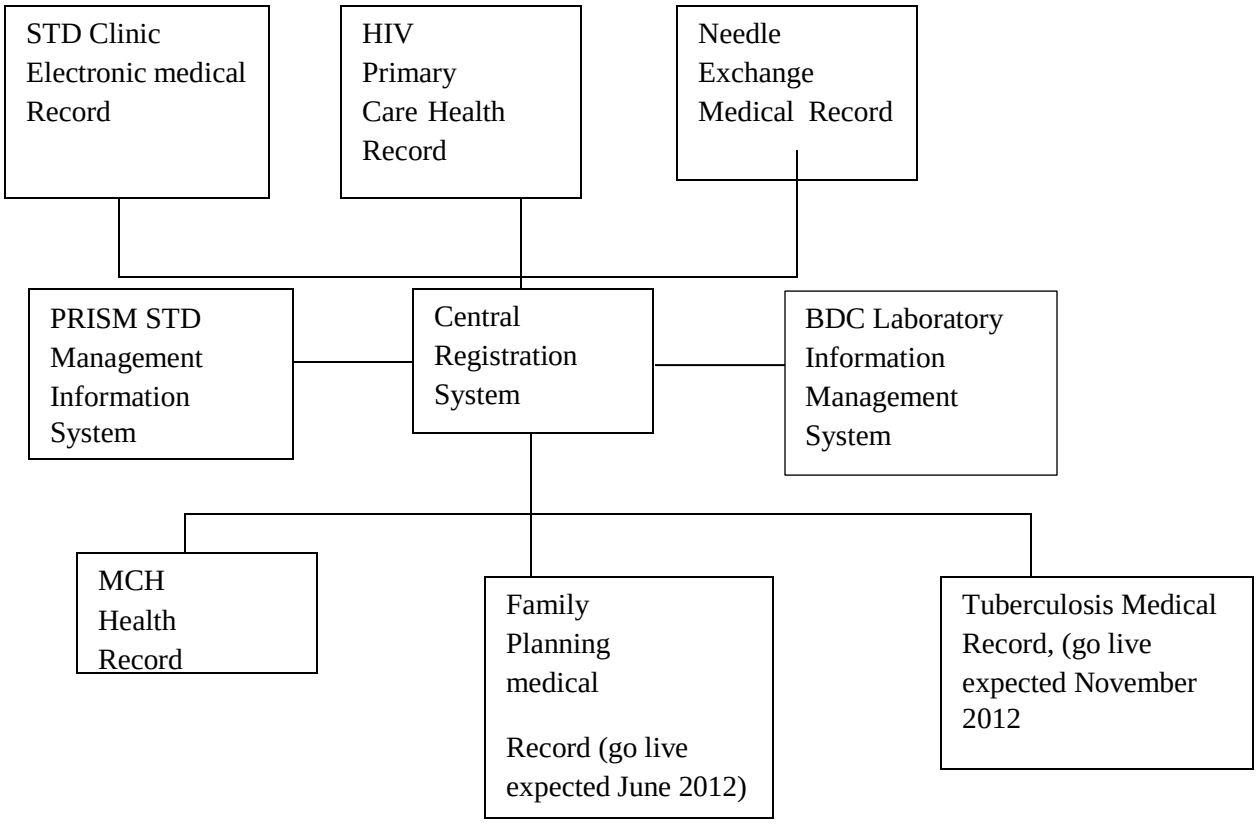
These antiquated, ensiled systems don't lend themselves to efficient management and data analysis and supply useful, timely information to healthcare providers CBOs and the general public. To address these limitations we are implementing the following changes:

1. BCHD and DHMH are working to implement the PRISM software system. PRISM is open source software developed by the state of Florida. It is web-based and will be a shared management system between DHMH and BCHD STD/HIV. This improvement will result in:
   - Any HIV cased entered in the system, in any county in Maryland for partner services will be available for case management throughout all jurisdictions in Maryland.

- Record searches will be streamlined into one system as compared to the current arrangement that relies on two separate databases for both DHMH and BCHD.
- Adaptation of the Linkage to Care and Outreach software developed in Baltimore City on the STD/MIS platform will allow other jurisdictions to adopt these management information systems for their own use.
- There will be common definitions for all shared variables making comparisons across jurisdictions easier to complete and more reliable.

2. We are currently working with a software developer to replace the aging BDC laboratory system. The new system will be open source software and will replace the functionality of the old BDC LIMS. In the STD clinics ordering of tests and providing test results to patients is a paperless process. There are no lab requisitions, or result forms. This project is expected to be completed in March of 2013. Further funding is being sought to allow this same type of order entry to be applied to our outreach testing, our needle exchange testing, our Family Planning and Health Teens Program, our school-based health centers, and some FQHC testing contractors. It is not possible to provide a timeline for these efforts since sufficient funding has yet to be identified.

3. A diagram of the envisioned information system is provided below:



These improvements will:

- Reduce the amount of time spent on data entry allowing those resources to be spent on improving data quality.
- Increase the amount of data readily available by reducing the time required to clean and convert data into modern software formats.
- Improve our ability to characterize HIV clients through substantial data integration.
- Provide higher quality patient data for the HIV Planning Group that improves decision-making about resource utilization.

5.2 Data Sharing

While Baltimore City is separately funded for HIV Prevention, HIV surveillance for Maryland and Baltimore City remains the responsibility of DHMH. STD/HIV Prevention continues to be very invested in using the most current data to manage its programs and to provide information

to its CBO prevention partners. The program continues to receive a substantial proportion of the reported new cases of HIV in a timely manner (80-85%), primarily because providers often assume the laboratory is reporting, they sometimes don't report cases of STD or HIV. All laboratory reports for HIV are sent to DHMH. STD/HIV does not have access to these reports in real time. This limits our ability to interview new cases of HIV within 30 days of diagnosis very difficult. The primary obstacle to our ability to have complete data sharing is that our physical space does not meet the CDC guidelines for confidentiality for STD Hepatitis, TB, and HIV programs. We are currently working with BCHD senior management to address this issue. Once this issue is addressed, we plan to develop a procedure to achieve access to all new reports of HIV in real time.

Data Sharing Update*

The implementation of PRISM will enable BCHD to share information in real time with DHMH and other jurisdictions that have updated their data security and confidentiality requirements in order to share information with the state. Currently, BCHD continues to receive morbidity reports each month from DHMH. BCHD has been reconstructing its website, and as of July 2014, has a webpage for HIV/STD surveillance data and resources (http://health.baltimorecity.gov/node/709).

5.3 Correctional Facilities

Overview

Maryland rated third in the U.S. with respect to the number of HIV-positive person in correctional facilities. DHMH estimates that nearly 75% of all incarcerated individuals (1,525 inmates) will return to Baltimore City after their release. Inmates throughout the U.S. continue to be disproportionately impacted by HIV/AIDS. Substance abuse and mental health disorders, both of which are connected to increased high-risk behaviors, are prevalent among the incarcerated population in the U.S. and are believed to contribute to the high rate of HIV infection in this population. With 2.5% of inmates HIV-positive or having a confirmed AIDS diagnosis, Maryland ranks third among all states. Data from the DHMH shows that 5.2% or 1,525 of the

29,070 living HIV cases in Maryland on June 30, 2010 were residents of state correctional facilities at their time of diagnosis. The corrections population also accounted for 3.5% of all new Maryland infections between July 2009 and June 2010. In terms of disparities, the inmate population is 85% male and over-represented by racial minorities, with 88% black, 10% white, 0.8% Hispanic, and 1.7% other. The prevalence of HIV in Baltimore City jails is estimated to be around 2%. This is significantly higher than the overall HIV prevalence in US correctional facilities. Of the more than 2 million incarcerated individuals in the US at the end of 2010, approximately 1.4% were estimated to be living with HIV/AIDS. Given that 1 in 7 individuals with HIV are estimated to pass through these settings each year, correctional facilities represent an important locale for targeted prevention interventions.

Testing

In response to a dramatic crack and commercial sex work related outbreak of syphilis in the mid to late 90s, DHMH instituted a stat testing program for HIV and syphilis at intake in Baltimore City jails. While funding has not been sustained at its original level for 16 hour a day staffing, it continues to provide a substantial of testing for syphilis and HIV to the DOC intake population. A table of outcomes for the last three years is provided below:

Baltimore City Detention Center StatLab Syphilis and HIV Screening Summary 2009-2011

	2009		2010		2011	
	n	%	n	%	n	%
Detention Center Population						
Number arrested	63,147	--	58,959	--	56,684	--
Number committed	30,410	48%	29,935	51%	30,287	53%
Syphilis						
Number screened	10,436	--	14,949	--	14,012	--
Number reactive	437	4%	455	3%	381	3%
Number of early syphilis cases identified	25	6%	11	2%		
HIV						

Number screened	2,870	--	5,294	--	6,006	--
Number positive*	57	2%	74	1%	90	1%

NOTE: Data are not de-duplicated

*HIV positive lab result does not necessarily indicate newly identified case

It is likely that some of the reasons described above, such as fear of stigma, explain the discrepancy between the number of syphilis tests and the number of HIV tests. In addition to the testing at intake, the program described below offers testing at the initial medical screening which occurs after the inmates may have been offered testing at the Statlab. It is important to note that many inmates are processed through the system at times when Statlab services are not available.

In 2008, the Baltimore City Department of Corrections, in collaboration with DHMH, implemented a voluntary opt-out rapid HIV testing program in all correctional facilities. Under this program, HIV testing is offered to all inmates at their initial medical screening. Inmates can also request testing during subsequent visits to medical facilities, and medical providers may refer inmates for testing based on symptoms. A study by Beckwith and colleagues (2012) examined the facilitators and barriers to implementing opt-out rapid HIV testing in Baltimore City jails, as well as 2 other cities. From May 2008 to April 2009, approximately 13% of individuals admitted to the Baltimore jail system were offered rapid HIV testing. Acceptance of HIV testing was found to be low with a 22% acceptance rate. Nevertheless, the program identified and treated 7 new cases of HIV. It was estimated that the rate of linkage to care upon inmate release was 45% during this period. The authors concluded that HIV testing in larger jail settings was feasible.

Although HIV testing has been shown to be feasible in correctional facilities, there are several challenges to implementation in these settings. The rapid turnover, particularly in jails, allow for the possibility that individuals are missed if the initial medical screening does not occur immediately. In their study of Baltimore City jails, Beckwith and colleagues cited a 3 to 4 day delay in HIV testing at intake. Low acceptance rates by inmates constitute another challenge to implementing HIV screening in correctional populations. The reasons behind these refusals

include perceived stigma, fear of a positive diagnoses, and concern regarding medical confidentiality.

There are other prevention methods that may be effective in Baltimore City correctional facilities. The CDC recommends that education prevention and counseling be provided for inmates (CDC, 2012). Additionally, condom distribution, needle-sterilization supplies and treatment for substance abuse and mental health disorders may help to reduce HIV acquisition and transmission among inmates as well.

Linkage to Care and Discharge Planning

Given the higher prevalence of HIV among inmates within the Maryland correctional system, there is justification for comprehensive services, including counseling/testing and primary care. A 2006 study revealed that 60% of released inmates in Maryland return to live in Baltimore City, thus making the needs of this population particularly pronounced in the Baltimore EMA. Prior to their release, newly-released inmates require transition services to promote continuity of medical care, to obtain assistance for mental health and substance abuse issues and to connect with programs geared to reducing recidivism. The lack of employment and job readiness services, (not covered under Part A) results in former inmates' focusing much of their energy on economic survival, pushing engagement in HIV care to a secondary priority. Ryan White is the only federal program designed to support services for people with HIV/AIDS and is a major source of care for inmates who have been recently released.

Apart from primary medical care, service gaps include medical case management, housing, employment, substance abuse services, counseling to improve health literacy, and mental health services. While newly-released inmates have several treatment options, there usually are eligibility restrictions and waiting periods that impact access to treatment. Further, eligibility is also affected by the status of being a recently released inmate, because some programs impose service restriction on this population. Intensive discharge planning programs are needed to ensure continuity of HIV care among newly released inmates, since only 28% enroll in an HIV clinic within 90 days.

Strategies

As described above, PHPA STD and HIV are heavily involved in DOC as well as DIS staff from Baltimore City. Both the percent of people tested above and those linked to care need improvement. Because of the complexity of the correctional system, its 24-hour operation, emphasis on security, challenges to confidentiality, vagaries of the justice system, it will take a concerted effort to make sustained improvements to HIV testing and care linkage.

As of 2012, BCHD has a Memorandum of Understanding with the Baltimore City jail to link HIV positive inmates with care at the time of their discharge. Their discharge and care plans will be reviewed and they will receive services from our Linkage to Care Teams. A detailing of some of the expected activities is provided in the timelines and objectives section of this document.

Correctional Facilities Update*: information provided by the HPG Corrections Workgroup

The Department of Public Safety and Correctional Services (DPSCS) has a robust detection surveillance and treatment program for HIV within Baltimore city jails, which include voluntary testing upon completion of Intake and associated RPR testing. The testing includes clinical blood as well as rapid kit testing in conjunction with DHMH. The BCHD Ryan White program is a part of the component of reentry discharge planning in the jail and statewide – state wide, 78% of the prison inmates are identified as Baltimore City residents. There is also a contracted medical discharge planning component for HIV-positive inmates about to be released, consisting of a 30-day supply of HIV medication upon release, and eligibility for Medicaid enrollment in a Managed Care Organization (MCO) with confirmation of attendance of first medical care appointment.

The following table shows the voluntary HIV testing data for the Baltimore region for the years 2010 – 2013:

	2010	2011	2012	2013
Sentenced tests	5939	5391	4304	2716
# positives	29	29	22	7
% positive	0.5%	0.5%	0.5%	0.3%
Detention tests	4505	5782	4226	5540
# positives	64	54	30	65
% positive	1.4%	0.9%	0.7%	1.2%
Total tests	10444	11173	8530	8256
Total positives	93	83	52	72
% positive	0.9%	0.7%	0.6%	0.9%

The following table shows the voluntary testing data for the booked and committed populations of the Baltimore region for the years 2010 – 2013:

VOLUNTARY TESTS	2010	2011	2012	2013
TOTAL # BOOKED	78365	71688	61357	55974
TOTAL # COMMITTED	18051	15373	13812	13650
# TESTED	4505	5782	4226	5540
# OF POSITIVES	64	54	30	65
% OF BOOKED POPULATION	5.7%	8.1%	6.9%	9.9%
% COMMITTED POPULATION	25%	37.6%	30.6%	40.6%

5.4 Substance Abuse Services

The primary provider of substance abuse treatment programs in Baltimore is Baltimore Substance Abuse Systems (BSAS). BSAS is responsible for defining and meeting the City's need for alcohol and drug treatment and prevention services. It plans, develops, and implements a comprehensive and integrated service system, managing state, federal and local grant funds. BSAS coordinates and monitors the delivery of alcohol and drug abuse services provided by all grant-funded programs. In 1990, the City of Baltimore was awarded the Target Cities Cooperative Agreement by the Federal Center for Substance Abuse Treatment. Baltimore Substance Abuse Systems, Inc. was created as a quasi-public, non-profit corporation by the Baltimore City Health Department to administer the implementation of the Target Cities Project. The aim of the grant was to improve the quality and effectiveness of the City's response to substance abuse.

In February 1995, the duties of the Baltimore City Health Department Substance Abuse Bureau were transferred to BSAS, thereby establishing the organization as the substance abuse authority for Baltimore City.

Severity of the problem

Substance abuse is an important contributor to a multitude of public health problems in Baltimore City. For example, the prevalence of injection drug use is estimated to be 162 per 10,000 population, second among the largest metropolitan statistical areas in the United States, and the 14% prevalence of HIV among IDUs in 1998 ranked the city 11th among the largest metropolitan statistical areas in the United States. The impaired judgment that occurs when people are under the influence of alcohol and other addictive substance is a contributor to the transmission of STDs and HIV. In addition, the addictive substances lead to an exchange of sex for drugs which enhances transmission even more. Injection drug users who exchange sex for money or drugs may serve as a bridge group for transmitting HIV between injectors and non-injectors. Because of these factors and the incidence of addictive behaviors in Baltimore, substance using populations will remain an important group for testing throughout this project period. We do not plan to spend behavioral intervention prevention funds for evidence based

interventions in this population because:

- When these clients are living in the street under the grip of their addiction, their receptivity to and availability for any sort of behavioral intervention is very limited, if they can even be found.
- If they are in treatment, they have already made the most important decision they are going to make about reducing their HIV risk. They are in substance abuse treatment.
- In addition, DHMH has received funding from SAMSHA to implement an HIV prevention project called No Wrong Door. DHMH is contracting with BSAS to implement a testing program combined with EBIs found to be successful in substance abuse settings. The project period for this grant is several years. The funds are specifically for the Baltimore EMA, so it is expected that many of these resources will be applied in Baltimore City.

Strategy

Taking these points into consideration, we will:

- Develop a quarterly meeting to determine which substance abuse sites are providing testing through the No Wrong Door Project:
- Offer testing at substance abuse treatment sites not covered by the No Wrong Door Project.
- Continue to offer testing at numerous street locations that are known to be high drug trafficking areas in order to provide testing to large numbers of people who are not in treatment.
- Continue to monitor Drug Abuse Warning Network Data semi-annually to monitor any new trends in Emergency Department visits for emergency substance abuse treatment.
- Continue to work with BSAS to increase capacity to provide testing at substance abuse treatment sites.

5.5 Mental Health Services

Substance abuse and mental health issues are tightly intertwined and often interact with each

other in a synergistic manner. A review of statistics regarding Baltimore's disproportionate share of the mental illness disease burden is quite sobering. One out of 20 adults have a serious mental illness such as major depressive disorder, bipolar disorder or schizophrenia. One out of 25 adults needed both mental health and substance abuse treatment. While Baltimore represents 11 percent of the state's population, it represents 33 percent of those who used the state's public mental health system. Expenditures of over $225 million for Baltimore City account for 35% of total expenditures on public mental health services in Maryland.

Services

Much like BSAS, Baltimore Mental Health Systems (BMHS) is a quasi-government agency. BMHS is a non-profit agency that serves as the City's local mental health authority or core services agency. BMHS focuses on: ensuring no one goes without mental healthcare; expanding and improving the range of services available; and ensuring accountability and active collaboration with city and state agencies. BMHS promotes prevention and early intervention, improves the quality of services by setting nationally accepted standards and promoting evidence-based and promising practices, and ensures sound fiscal management of public funds. BMHS oversees a network of predominately private non-profit providers that delivers mental health services to Baltimore City residents who are Medicaid and/or Medicare recipients or uninsured. BMHS awarded 18.9 million through 137 contracts to 60 unique provider agencies. In the last year:

- 15,427 children/adolescents and 26,065 adults received public mental health services
- 39,244 received outpatient treatment services
- 438 received supportive employment services
- 584 received residential crisis services
- 60 homeless individuals moved into permanent housing
- 36 youth diverted from institutional Residential Treatment Centers into community-based care

Practice

STD/HIV has no formal association with BMHS. Each year our sole health educator, Bernard Gibson, provides STD/HIV education for several of the residential treatment facilities in the city. This is not formally set up, but occurs, essentially by word of mouth. There is no regular contact between BMHS and the management of the STD/HIV program.

Strategy

Providing HIV prevention to people with mental illness is complicated. If they are on the street, the program's staff lacks the expertise to assess their readiness for testing. Within treatment facilities, they are typically in a strict treatment program. In short, STD/HIV staff would need to be invited to provide testing or prevention education. In order to ensure that these invitations occur, the STD/HIV Prevention Program will need to market its services to in concert with BMHS. A further description of this activity is provided in the timetable/objectives portion of this plan.

5.6. Behavioral Health – The Merging of Substance Abuse and Mental Health*: information provided by the Department of Health and Mental Hygiene, Prevention and Health Promotion Administration

Mental health challenges and substance use disorders are commonly jointly referred to as behavioral health problems. Behavioral health disorders often co-occur and exacerbate one another (See Appendix B for national and state data on the co-occurrence of behavioral health disorders). The frequency of this co-occurrence was one of the major factors leading the formerly separate Baltimore Substance Abuse Systems and Baltimore Mental Health Systems to merge in October 2013 to become Behavioral Health System Baltimore (BHSB) in order to further integrate their efforts to support persons with behavioral health disorders in Baltimore. BHSB monitors the delivery of substance abuse and mental health services provided by grant-funded programs in order to aid in the development of a more efficient and responsive system

that comprehensively addresses mental health and substance abuse in Baltimore.[7] Similarly at the state level, the formerly separate Maryland Alcohol and Drug Abuse Administration and Maryland Mental Hygiene Administration have merged, effective July 1, 2014, to become the Maryland Behavioral Health Administration.

Behavioral health disorders represent an enormous challenge in addressing the HIV epidemic. Behavioral health disorders increase an HIV-negative person's vulnerability to HIV infection. For persons living with HIV, behavioral health disorders can challenge their ability to engage in care and adhere to HIV medication regimens. One of the ways in which these challenges are being addressed is the *No Wrong Door* project.

The No Wrong Door Project

No Wrong Door is designed to integrate HIV prevention and care with substance abuse and mental health services. The DHMH's Prevention and Health Promotion Administration Infectious Disease Bureau sought and obtained funding from SAMHSA to implement the No Wrong Door concept in the Baltimore metropolitan statistical area. Maryland is partnering with the Behavioral Health Administration, BHSB, the University of Maryland Baltimore County Center for Community Collaboration, STAR TRACK, the Anne Arundel County Health Department, Coppin State University, Morgan State University, AIDS Action Baltimore, and LIGHT Health and Wellness/Older Women Embracing Life to pursue the vision that a client may enter any of the doors of the local behavioral health and infectious disease systems and find their way to all of the other services they need across disciplines. See Appendix C for a diagrammatic description of the No Wrong Door Project.

No Wrong Door began with a baseline assessment of substance abuse and mental health providers in Baltimore to answer the question of how sexual health was being addressed in those settings. E.g., did the programs ask about the sexual behavior, sexual orientation, and gender

[7] Baltimore Behavioral Health System. (2014). *Baltimore behavioral health system.* Retrieved from http://www.bhsbaltimore.org/.

identity of their clients? Did they offer HIV and other infectious disease testing? Did they support clients in reducing their sexual risks? No Wrong Door continued with the development, piloting, refinement, and dissemination of an Integrative Screen which helps identify client needs across the domains of mental health, substance use, and sexual health. The Integrative Screen also assesses a client's readiness for a referral to the needed services.

With No Wrong Door funding, the following programmatic efforts are underway in Baltimore:

- BHSB is offering a Sexual Health Learning Community to mental health providers to build their comfort, knowledge, and skill conducting sexual risk reduction counseling with their clients.
- BHSB is purchasing additional substance abuse treatment slots to expand the availability of needed addictions services.
- Coppin and Morgan State Universities are building substance abuse and HIV prevention programs for young, African American MSM and their peers using a peer educator model.
- The University of Maryland Baltimore STAR TRACK program is providing case management to young, African American MSM, regardless of HIV status. STAR TRACK is also implementing RISE (Rewriting Inner Scripts), a behavioral intervention designed to raise participants' consciousness regarding the impact of internalized oppression (e.g., racism, heterosexism, homophobia) on the way they feel about themselves, their peers, and their community; RISE also teaches self-parenting/self-management skills and risk reduction, and encourages young MSM to enroll in other needed services.
- AIDS Action Baltimore is providing mental health services to transgender women.
- Older Women Embracing Life is providing Sister 2 Sister and WILLOW, two CDC-recommended interventions.
- DHMH is offering training on Sexual Health in Recovery (SHIR), an intervention for persons in recovery from substance abuse disorders. Many clients enter addictions treatment with well-established habits of having sex under the influence. SHIR gives

clients' tools for decoupling their sex lives from their drug- and alcohol use in order to prevent these habits from causing them to relapse

- BHSB is subcontracting with Total Health Care to bring infectious disease testing and linkage services to other substance abuse treatment providers.
- BHSB is subcontracting with Baltimore Crisis Response, Inc., to bring infectious disease testing and linkage services to other mental health providers.

The following table shows the number of HIV tests conducted in Baltimore City through the No Wrong Door Project, the number of positive individuals, and the number of newly positive individuals from 2013:

Number of Tests Conducted	Number of Overall Positive Clients	Number of Newly Positive Clients
1375	6	2

5.7 Private Sector Collaboration

Opportunities for Private Sector Participation

In 2011, private physicians, hospitals and clinics reported 120 of the 372 newly identified HIV cases reported to Baltimore City. In 2010, the official statistics from HIV Surveillance at PHPA reported that there were 406 newly identified cases of HIV in Baltimore. Unfortunately there is no reason to believe there has been a decline, so there are probably 82 cases or more that we did not receive in 2011. We have begun remedying this issue by receiving a list of reported cases from the state each month. We cross-tabulate this list with people who have already been reported to us and initiate, anyone who we were not yet aware of, for partners services. The other important factor is the generally accepted estimate that 20% of those with HIV are not aware of it, thus an estimate just for the incident cases in 2011 would be that there are additional 101 people who are not aware of their HIV status. We need assistance from the private medical sector in both of these areas.

Reporting

Since all HIV positive laboratory reports are sent to the PHPA HIV Surveillance Program, the 82 cases that were not reported to BCHD in a timely way were probably by physicians, and PHPA HIV Surveillance staff used the laboratory reports to contact the physicians and get further information about the patient. This percentage of non-reporting is very consistent, in fact, somewhat better than the percent of physicians who report Chlamydia cases to the health department. We will need to develop strategies to improve coordination or reporting. The least labor and resource intensive strategy is to implement the activities in table 4.2 regarding data sharing. In this way, we will get the information on all newly-identified positives in a timely manner, and it will be much more efficient than trying to change the reporting habits of the entire medical community.

Assistance in Identifying the 20% of HIV-infected Persons Unaware of Their Infection

The 121 cases reported by the private medical sector were reported by 71 different providers. The Health Department is providing testing at many of the obvious sites and reaching out to people who have a high level of demonstrated risk for contracting HIV. It is likely that a substantial proportion of the persons reported by the private medical sector do not meet the same level of risk as those identified by the health department or those identified by Chase Brexton, (a clinic whose patients are primarily gay males). Anecdotally, we have experienced two types of persons who often don't get tested, those who are aware that they have engaged in very risky behavior and simply choose not to get tested out of fear of the results and those who have no perceived risk. Persons with no perceived risk are not likely to be found in a high drug trafficking area, in a substance abuse treatment facility, or in an after-hours club, primarily frequented by young African American MSM. Routine testing in the private sector holds promise for finding newly-identified HIV positives who don't perceive themselves at risk. If increased private sector testing is to be sustainable, it must be billable.

Strategy

Our thinking is that increasing private sector testing will result in identifying a large portion of

those persons who are not aware of their HIV status. Part of the strategy will need to be to make routine HIV testing billable. A further description of this strategy with a timetable is provided in the Goals/Timetable section of this plan.

Private Sector Collaboration Update*

Protect Baltimore, the Category C detailing project addresses the need to increase routine HIV testing among primary care providers. In addition, BCHD is currently working to assist community health centers, hospitals, and other providers in negotiating the changing landscape regarding HIV testing and reimbursement. Through the development of a billing and reimbursement workgroup, as well was meeting with stakeholders who have experience with billing and reimbursement, BCHD aims to:

- Help HIV prevention providers and other providers to increase their capacity to seek reimbursement for services covered by insurance carriers, including private insurance companies, Medicaid, and Medicare.
- Establish systems that allow for third party reimbursement
- Build our capacity/ability to provide technical assistance to effect necessary changes to local providers.

5.8 CBO Capacity

HIV prevention community-based organizations in Baltimore have faced continuing loss of infrastructure funding and some loss of leadership for several years. The most notable loss that will be used as a beginning of this description is the collapse of the HIV/AIDS Education Resource Organization (HERO). HERO was one of the longest serving HIV/AIDS organizations in the United States when it closed its doors in late November 2008. In addition to HERO, there were at least five organizations that provided HIV prevention and testing services that were directly funded by CDC. This funding was approximately $1,000,000. These organizations had been successful at sustaining this funding for 10 years. In 2009 a request for applications to continue this funding was released by CDC. None of the five previously funded organizations in Baltimore received any of this funding, thus the city sustained a loss of $1,000,000 and three of

these five organizations were unable to sustain themselves. Subsequently, an RFA for direct funding from CDC for testing projects among African American MSM and African American transgender persons was released. Despite three or four organizations applying for MSM funding none was received in spite of a significant increase in syphilis and HIV transmission in the African-American MSM population.

The Baltimore EMA received Enhanced Community HIV Prevention Planning funds. RFPs for testing were released in October of 2011. The city received 6 proposals, only one passed the technical review sufficiently to be funded. One was later funded after a resubmission was requested. A subsequent RFA was released and one applicant was able to be funded after a clarification meeting.

Strategy

There are clearly issues of capacity that need to be addressed. We will provide an enumeration of some of those activities in the objectives/timetable section of this document.

CBO Capacity Update*

In an effort to build up CBO capacity, BCHD is working with the House Ball Coalition to obtain status as a 501(c)(3). Furthermore, we are also funding four community-based organizations (Health Care for the Homeless, AIDS Action Baltimore, LIGHT Health and Wellness, and HopeSprings) to conduct their evidence-based interventions designed to provide support services for those already living with HIV, and those at high risk of obtaining HIV.

5.9 Human Resources/ Personnel Capacity

As a newly funded HIV prevention program, the STD/HIV Prevention program, Baltimore City Health Department is wrestling with the appropriate staffing pattern to manage the programs that it will now be responsible for. There are two areas of staffing and management that are especially challenging:

1. The program lacks staff with experience in implementing and evaluating Evidence-Based

Interventions (EBIs). The difficulty with decision-making around how much to invest in staff development on this issue is complicated by the change in emphasis toward testing, linkage to care, partner services and prevention with positives. It is thus somewhat difficult to determine how much human resources infrastructure to build around the implementation and management of EBIs. It may be more efficient to contract this function to a contractor that already has the requisite expertise.

2. Many aspect of the management of partner services are supported by federally assigned staff from the NCHHSTP, STD Program, Field Services Branch. The number of these staff available has been shrinking since 1994 or 1995. There is also some thought being given to making their positions more regional in nature. With these considerations in mind, it is important to budget for and develop local management staff to take over these roles.

5.10 Pre-exposure Prophylaxis (PREP)*: Information provided by the HPG PrEP Workgroup

Recognizing the scientific evidence of Pre-exposure Prophylaxis (PrEP) with daily oral Truvada as an effective tool for HIV prevention for those at risk, the Baltimore City HIV Planning Group and Commission formed a PrEP workgroup. The purpose of this group is to examine the current and potential use of PrEP as a prevention strategy to decrease the acquisition of HIV in high-risk uninfected men who have sex with men (MSM) and transgender women in Baltimore City. This effort is consistent with the new CDC Guidelines on the use of PrEP in the US, and with the new WHO Guidelines on Prevention, Treatment and Care for Key Populations, which recommend PrEP be considered as an additional prevention option for MSM as part of a comprehensive package of prevention services. Leaders in the field of HIV and HIV prevention from the community, clinics (community-based and academic), policy-making organizations, and the Baltimore City and Maryland State Health Departments were recruited. The first meeting of this group took place on April 25, 2014. During that meeting, members shared their knowledge of and experience with PrEP as a tool for HIV prevention and discussed barriers to PrEP utilization in Baltimore. Within the working group, three subgroups emerged:

- Community activists

- Health care providers
- Policy makers and governmental agencies

These subgroups were charged with developing plans to address the barriers to PrEP identified. Barriers identified include lack of community awareness, inadequate systems and medical provider training to effectively prescribe PrEP, possible reimbursement issues, and lack of funding for PrEP-related activities.

The healthcare provider subgroup had a follow-up meeting on June 12, 2014, during which representatives from the participating medical institutions shared existing PrEP practices, protocols, and resources. The representatives agreed to develop a task force at their respective institutions. The purpose of the task forces is to provide leadership in PrEP implementation at their institutions in the areas of:

- Patient education and outreach,
- Protocol development,
- Systems of PrEP delivery and patient referral
- Medical provider and staff training
- Data monitoring and evaluation

The subgroup also plans to administer a survey of PrEP attitudes and practices to medical providers in Baltimore City. This survey will be based on existing surveys utilized at other institutions. Other activities of interest to the workgroup include:

- Development of best practices for Baltimore City clinics to provide PrEP
- Dissemination of PrEP training programs for medical providers, nurses, staff and HIV testing/counseling personnel
- Identification of areas of funding for PrEP-related activities.

Task forces have met in July/August 2014, and a follow up meeting of the subgroup is planned for August 15, 2014. Members of the subgroup have connected with PrEP clinics across the

country to share protocols, best practices, and resources for successful PrEP implementation. These clinics include a clinic in Boston, Massachusetts and one in San Francisco, California.

On July 31, 2014, the first meeting of a participating medical institution's PrEP Task Force took place and included representatives from the institution's adult and adolescent medical clinics serving HIV-infected and HIV-uninfected patients, and PrEP researchers and leaders in HIV prevention from the institution's School of Public Health. The Task Force agreed to develop a clinical PrEP protocol and to offer PrEP training to medical providers and staff; discussed the medical and logistic elements important to include in the protocol; and agreed to establish a system of referral to PrEP clinics from other institutional medical providers. The protocol development and provider and staff training will be done in partnership with the PrEP Task Forces established at the other participating institutions and the Baltimore City STD Clinics. The Johns Hopkins University Center for AIDS Research will also be highlighting PrEP in Baltimore at their World AIDS Event on December 1, 2014.

The working group is collaborating closely with the Baltimore City Health Department Bureau of HIV/STD Services and the Baltimore City HIV Planning Group and Commission to ensure that there are coordinated efforts to effectively integrate PrEP as a tool for HIV prevention in Baltimore City. On July 31, 2014, members of the healthcare provider sub group consulted with the Program Manager for UCHAPS (Urban Coalition for HIV/AIDS Prevention Services) to initiate a request for capacity building assistance to facilitate:

- Development and dissemination of the survey of medical providers regarding PrEP
- Analysis and evaluation of the survey
- Identification and solutions to systemic barriers to PrEP (i.e. third party reimbursement, other cost and follow-up care)
- Community mobilization and education.

The New York City and San Francisco Health Departments are funded by the CDC to provide capacity building and technical assistance for HIV Prevention strategies including PrEP. This group chose to request technical assistance from the San Francisco Health Department due to

their breadth of experience promoting PrEP across multiple healthcare settings, including STD clinics, women's health facilities, and private insurers. Once survey results are analyzed and the identified gaps in education, skills, and practice are addressed, this committee will engage in an informed community mobilization effort to provide education and information on how and where to access services around the city.

6. Goals and Objectives*

Below are the goals and objectives of the Jurisdictional Plan, along with an update on the progress and barriers in achieving them.

3.2. Testing Strategies

Goal: Implement a testing strategy that will achieve at least 20,560 tests per year in non-clinical sites by the end of the fifth year of the project period while maintaining a 0.5% identification rate for new positives.

Objective	Responsibility	Progress and Barriers
Continue to fund and maintain outreach testing in Baltimore City Health Department and with CBO providers.	STD/HIV Prevention Program Management	We continue to fund and maintain Outreach, STD, ED, and CBO funded testing. In 2013, we completed 17509 publicly supported tests among our non-clinical sites and the overall new positive identification rate was 65 (0.37%)
Monitor testing effectiveness and provide quarterly feedback to funded CBO providers.	Epidemiology Staff	This feedback is provided on annual site visits and more frequently if performance is an issue.
Use data and findings from the Category C project to better target testing.	Category C Staff STD/HIV Prevention Program Management	We geo-mapped and classified high and very high HIV morbidity areas. We subsequently identified 11out of 110 high and very high morbidity areas that were not receiving testing services. The Outreach Program has been methodically trying to provide testing in those 11 previously unserviced areas (See Appendix E). Currently, our program has tested in 9 of the 11 areas.

		Our new outreach schedules are developed inclusively so that we provide services evenly amongst areas with the highest morbidity. The remaining two areas will be added in the upcoming month.
As funding allows and data suggests, release RFAs for new or replacement CBO testing contractors.	STD/HIV Prevention Program Management	The testing performance of our funded CBOs has been sufficient to continue funding the same group of CBOs.
Continually monitor testing and surveillance to identify new areas and populations for whom testing should be emphasized.	Epidemiology Staff BDC laboratory Staff Category C Staff Outreach Staff DIS Staff	The Category C funding is currently primarily serving this purpose. The program has implemented a protocol that ensures that when a new HIV positive person's viral load is high, a set of steps rapidly occurs: 1. The BDC laboratory emails a list of viral loads over 50,000 to a large group of people. The list has no Personally Identifiable Information (PII) on it, but recipients can look people up in password protected databases. 2. A research assistant confirms that the HIV Reactor manager receives the reports. 3. The Reactor Manager screens the reports and determines whether they are new or previous positives. 4. New positives are sent for intensified Partner Services and linkage to HIV primary care.

		5. Previous positives are sent to the Care Linkage staff. 6. Part of intensified partner services is to ask the infected patients about sex partner meeting places. If viable locations are identified, the outreach screening van will provide screening at those locations as soon as possible.
Monitor the EDs' productivity trends to evaluate achievement of testing goals and objectives and provide feedback to the ED administrators on a biannual basis and as needed	STD/HIV Project Officers	This activity has been ongoing. ED productivity has been monitored throughout the project. Testing was stopped at two EDs because the number of cases identified ((0) and (1) respectively in 12 months or more) did not justify the funding allocated.
Work with ED administrators to identify the times of the day and days of the week that are most productive, and the staffing levels needed to achieve the testing goals and objectives	STD/HIV Project Officers	This has been done repeatedly throughout this project period.
Promote and expand HIV testing programs to other EDs in high prevalence areas that currently do not provide routine HIV testing	STD/HIV Project Officers	We have tried on several occasions for the last seven years to include EDs from a specific hospital system. Thus far they have shown no interest.
Promote obtaining reimbursement for routine HIV services from third party payers and assist in developing procedures	STD/HIV Project Officers HPG Billing and Reimbursement Workgroup	This has been an ongoing activity that now includes a workgroup of the HPG.

	Program Managers	
Promote integrated routine testing in the healthcare settings and assist in developing procedures and implementing the model	STD/HIV Project Officers	This practice has now been adopted in all of our funded emergency department settings. It is also part of the educational aspects of our Category C physician detailing project.
Complete HIV tests through the STD Clinics testing efforts and identify new HIV positives:	Epidemiologists Project Managers	Ongoing
Monitor the Clinics' productivity trends to evaluate achievement of testing goals and objectives and provide feedback to the clinics administrators on a biannual basis and as needed	Epidemiologists and Project Managers	This is an ongoing and successful process.
Maintain staffing level to achieve the required testing goals and objectives	STD/HIV Program Management	The program is finally within six months of full staffing.
Follow up with the Maryland DHMH on clients who reside outside Baltimore City to get the partner services disposition	HIV Reactor Staff and Epidemiologists	We use the same out of jurisdiction procedure that has existed for STDs for the last 50 years.
Work with the participating healthcare settings' administrators to explore and identify mechanisms of obtaining third party reimbursement for routine HIV services and assist in initiating the billing procedures	Program Managers	This is a complex and ongoing endeavor. BCHD is partnering with DHMH, the HPG's reimbursement workgroup, and other key stakeholders and is seeking technical assistance from CDC-funded Capacity Building Assistance providers.

Invite participating healthcare settings and local providers to local and national forums, trainings, and discussions on reimbursement efforts for routine HIV testing services and program sustainability	Program Managers	We have been participating in nationally provided webinars.
Partner with CDC, the state health department, local AETC, and other capacity building and technical assistance agencies in disseminating information on reimbursement and providing trainings, technical assistance, and capacity building activities on third party reimbursement	Program Managers and BCHD Clinical Staff.	This has been an ongoing process. For example, in the fall of 2013 STD clinic staff, the CFO, and another Fiscal person attended a reimbursement boot camp provided by the CDC sponsored regional training center. The project was to help assess billing readiness.
Partner with CDC, the state health department, local AETC, and other capacity building and technical assistance agencies in disseminating information on reimbursement and providing trainings, technical assistance, and capacity building activities on third party reimbursement	BCHD HPG Billing and Reimbursement Workgroup	This is an ongoing process. Part of this process will be achieved through the HPG's billing and reimbursement workgroup reimbursement

3.4. Linkage to Care

Goal: Develop a care referral system that ensures that 85% of newly identified HIV positive persons who are encountered by the health department are linked to care.

Objective	Responsibility	Progress and Barriers
Continue to apply for funds from Ryan White Part A. to provide a Care Linkage team.	Care Linkage Coordinator	We continue to successfully apply for funds from Ryan White part A. and Ryan White Part B. that is managed by DHMH. In 2013, we received an increase from Ryan White Part B., and in 2014, BCHD received a certificate recognizing us for linking the most people to care in the state.
Work with Ryan White part A. to assess the sensitivity of the system for capturing when persons fall out of care.	Care Linkage Coordinator. Ryan White Part A. Management	This is still an ongoing project. DHMH received category funding to evaluate using the frequency of reported viral loads to assess care retention status. We will coordinate with them as they refine this strategy.
Adapt system to be more sensitive to when persons are lost to care.	Ryan White Part A. Management.	The work described in the previous row will inform the development of this system in an efficient manner.
As part of working with the Department of Corrections (DOC) as outlined in the gaps section of this document, work to improve the percent of released inmates who are linked to care.	Care Linkage Coordinator DOC Coordinator	We will continue to work on this objective. Data on the percentage of released HIV-positive inmates is still pending.

3.5. Care Retention

Goal: Leverage resources to improve care retention by partnering with CBOs to provide volunteers to assist HIV-positive clients to maintain themselves in care.

Objective	Responsibility	Progress and Barriers
Collaborate with JHMI and a local CBO that manages volunteers to write a Center for AIDS Research Grant to pilot an HIV buddy system staffed by multiple volunteers for each HIV positive person.	JHMI CCHR HopeSprings Volunteer Organization	This endeavor was completed and submitted; however, funding was not received.
Given award of funding, implement and evaluate program.	HopeSprings Volunteer Organization Program Management Project Officer	We implemented this as a pilot project in the second half of 2013 with funding from Category of the HIV Prevention Funds.
Seek further funding to expand program.	HopeSprings Program Management Project Officer	We have continued to fund this project in 2014 with HIV Prevention Funds.
Provide care retention partners to all HIV-positive persons who are interested in the program.	BCHD STD Clinic Staff JACQUES Initiative Staff	Thus far we have provided this service to clients from the Jacques Initiative and the Baltimore City Health Department Early Intervention Program. An important piece of information is that there is another screening process in addition to interest. A screening

	Program Management	tool that uses the stages of change model for behavior change is given to each possible client. Clients who appear to be ready for change are referred to this program.

3.6. Partner Services

Goal: Improve the effectiveness of HIV partner services as measured through increasing the HIV notification index from 0.4 to 0.8 before the end of the project period.

Objective	Responsibility	Progress and Barriers
Meet with DIS staff monthly to discuss performance issues and review cases	Senior STD/HIV Program Management	Monthly meetings have been held for the last two years.
Purchase Accurint Software to assist in reducing the number of people who are closed as unable to locate	STD/HIV Prevention Program Manager	Accurint was purchased in November of 2012. Anecdotally, staff has found it to be useful. We are planning an extensive evaluation in the next six months.
Implement the use of Accurint software to assist in finding hard to reach patients.	First Line Supervisors Asst. Program Manager	We have implemented the use of Accurint, since November of 2012. We have been able to convert persons who would have been closed as unable to locate to persons who receive an HIV test. The current policy is that an Accurint search occurs before anyone is closed as unable to locate. How well this process is occurring will be part of the evaluation described above.
Hire & Train a local DIS supervisor to reduce the current supervisors' span of control and thus ability to provide more comprehensive supervision.	First Line Supervisors Asst. Program Manager	This has not yet occurred. It was scheduled to have occurred by now. Thus far, a request to create a position has been completed (March of 2014). We are waiting for the Human Resources department to complete a new classification for this position. This has been held up by the Managerial and Professional

		Society (MAPS) salary comparison study which was just completed. We hope to be interviewing for these positions before the end of 2014.
Complete Human Resource upgrade process for Public Health Representatives to provide an opportunity for advancement.	Senior STD/HIV Program Management Depatment of Human Resources	Over the last decade, BCHD has lost a number of qualified Disease Intervention Specialists (DIS) to other jurisdictions. A salary survey of local jurisdictions has been completed and a two-step career ladder for DIS has been initially approved. The necessary documents to implement this change are currently with the Baltimore City Human Resources Department.
Increase the number of partner services interviews provided to HIV-positive persons who have contracted a new bacterial STD.	Program Director Deputy Director DIS Supervisors	This was implemented in late 2010 and the number of such interviews has increased annually. In 2013, we completed 69 interviews out of 93 (74%) co-infected with HIV and new bacterial STI reporting to STD clinics
Increase the percentage of newly-diagnosed persons who are referred and interviewed to partner services within 30 days to 73% by the end of 2013.		In CY 2013, 67.5% (287 of 425) of newly diagnosed persons were interviewed for partner services within 30 days of diagnosis date

3.7. Condom Distribution

Goal: Develop and maintain the infrastructure to successfully and efficiently distribute at least 1,000,000 condoms annually.

Objective	Responsibility	Progress and Barriers
Develop the mechanism for adding funding to the condom distribution warehouse so that Baltimore Organizations can continue to order condoms.	STD/HIV Prevention Program Manager	This mechanism has been set up and funding for more than a million condoms has been sent to the distribution center.
Ensure that the contact information for the distribution center is widely distributed.	STD/HIV Prevention Program Management	We have sent this information to people who call requesting condoms from the health department. We will add the information to the health department's new website.
Encourage persons who provide services to HIV-positive persons to enroll in the condom distribution program.	STD/HIV Prevention Program Management	This is an ongoing activity.
Monitor the number of condoms provided to HIV-positive service providers.	Epidemiology/ monitoring staff	The number of condoms provided to HIV-positive service providers pending
Develop a web-based program for HIV-positive persons to order condoms on the web**.**	STD/HIV Prevention Program Management	We have not yet implemented this project; however, we did collect emails at the last mini-ball. As a result, we plan to develop a distribution list from these emails and ask attendees if they would like to receive condoms by mail. We are collaborating with the Washington D.C. program to learn more about implementing this project.

3.8. Needle Exchange

Goal: Through the Expanded Syringe Exchange Program:

1. **Increase syringe coverage by 25% among syringe exchange clients in Baltimore City**
2. **Decrease syringe borrowing and lending behaviors by 20% among syringe exchange clients**

Objective	Responsibility	Progress and Barriers
Review existing syringe exchange regulations and laws, identify best practices in needs-based syringe exchange programs (site visits), identify pros and cons of expansion, and conduct a needs assessment	Bureau of STD/HIV Services Staff Legislative Staff Harm Reduction staff Harm Reduction Staff	It is possible that all of the activities on the left were not completed exactly as described; however, the outcome is that legislation allowing BCHD to adopt a distribution model for Needle Exchange was passed in March of 2014 and will go into effect on October 1, 2014. BCHD was required to promulgate regulations requiring that no more than 50 syringes could be obtained for each individual syringe returned. A copy of the Health Commissioner's response is provided as an Appendix
Planning: Produce a white paper of best practices, recommendations, and options for proceeding. Produce a policy brief that can be used to educate stakeholders on the proposed policy change. Introduce policy change.	Bureau of STD/HIV Services Staff Legislative Staff	See first paragraph

Capacity building: Hold staff meeting(s) to discuss proposed policy change and its implications for staff and clients. Arrange visits to key stakeholders to inform and educate them on the importance of a needs-based syringe exchange model.		See first paragraph
Implementation: Modify existing syringe exchange manual to eliminate 1:1 exchange language, begin needs-based syringe exchange	Bureau of STD/HIV Services Staff Legislative Staff	See first paragraph
Conduct a post-policy assessment	Bureau of STD/HIV Services staff	See first paragraph

3.9. Policy Initiatives

Goal: Develop a policy initiative focused on the prevention of perinatal HIV transmission.

Objective	Responsibility	Progress and Barriers
Implement a FIMR-HIV review process for the assessment of missed opportunities to prevent perinatal HIV transmission by the second half of 2013		After learning more about the FIMR review process and conferring with our colleagues at the state of Maryland, we determined that there were too many systems issues that needed to be addressed before it made sense to implement the FIMR Process. We have pursued a different path that is outlined in a new set of objectives outlined below.
Convene an initial Perinatal HIV Prevention stakeholders meeting.	STD/HIV Prevention Program Management	Representatives from DHMH HIV Surveillance, DHMH Perinatal HIV Prevention, BCHD Maternal and Child Health, DHMH STD Prevention, and BCHD STD/HIV Prevention met in the fall of 2013 to discuss collaboration opportunities to prevent vertical transmission of HIV. DHMH Surveillance provided an overview of the cases that had occurred between 2009 and 2011.
Hire a perinatal HIV prevention Coordinator.	STD/HIV Prevention Program Management	An excellent candidate has been offered a position and is expected to be on board by mid-August 2014 at the latest.

Receive a list of mothers and infants who recently experienced HIV perinatal transmission from the DHMH Perinatal HIV Surveillance Program.	DHMH Perinatal HIV Surveillance STD/HIV Prevention Program Management	We received the list in March of 2014.
Convene another meeting of the Perinatal HIV Prevention Committee to look for opportunities to collaborate and reduce perinatal transmission to zero with an additional emphasis on policy changes.	Perinatal HIV Prevention Committee.	Prior to this meeting, the MCH program reviewed the list of nine mothers and babies and learned that 6 of these women had been referred to Health Care Access Maryland for follow-up. We also learned that two of these women were closed as unable to locate. This resulted in the implementation of a new policy. If caseworkers who are subcontracted to provide outreach for MCH cannot find an HIV positive pregnant woman, they should be referred to the STD/HIV program for further follow-up efforts by a Disease Intervention Specialist. With respect to policy, the only idea that seemed to have traction with the group is legislating 3rd trimester screening for HIV. An additional point of discussion was whether or not an entire package of legislation should be put forward for STDs and HIV. A meeting will take place in October to discuss these issues with the appropriate staff from DHMH.

3.10. Evidence-Based Interventions

Goal: Provide behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV, particularly those in an HIV-serodiscordant relationship

Convene a series of facilitated meetings to discuss with community members how best to access and engage high-risk negatives.	Program Director Contracted Facilitator	Due to CDCs' de-emphasis on evidence-based interventions for HIV negative persons, we opted not to implement this process. We have continued to fund one evidence-based intervention for HIV negative transgender persons. It is unlikely that we will have any additional funding available to implement an RFA process to provide any further evidence-based interventions.
Use the input from the meetings to develop a request for proposals (RFP)	Program Management	See first paragraph
Advertise and announce the RFP in accordance with city procedures	Program Management	See first paragraph
Recruit and train a proposal review committee	Program Management	See first paragraph
Receive completed proposals	Program Management	See first paragraph
Inform the successful CBO applicant	Program Management	See first paragraph
Complete the 6 month Contract	BCHD Fiscal Program Management	See first paragraph

3.11. Social Marketing

Goal: Develop the Baltimorestatusupdate.com website to include educational activities and videos geared to the young MSM population, including a YouTube talk show

Objectives	Responsibility	Progress and Barriers
Work with the MSM community to have several activities owned and operated by the community on the Baltimore status update website by the end of 2013	All of these objectives will be the responsibility of the following: Community Projects Coordinator Young MSM Outreach Worker Program Managers and Development Team	None of the activities on the left have been implemented. This is primarily because we initially chose an individual to manage the Baltimore Status Update website. This person's skill set was not up to the task and the website fell into disrepair. We subsequently spent nearly twelve months implementing a contract with a company, "Sexual Health Innovations" to maintain the website. We are now reviewing content for the website. The activities to the left will not occur until sometime in 2015, at the earliest. We overreached on the objectives in light of the expertise and manpower available. In addition, the organizational capacity of this community has thus far not been able to respond to the activities described above. We have completed a technical assistance request from CDC providers to increase the organizational capacity of this community.

Develop a plan for regular web events such as a YouTube talk shows		See first paragraph
Get approval to implement website activities from the BCHD executive management		See first paragraph
In conjunction with community members, implement website activities		See first paragraph
Develop and launch at least two YouTube HIV educational videos in collaboration with the African-American MSM community by October 31, 2013		See first paragraph
Recruit team from the Program and the House-Ball Community		See first paragraph
Develop themes for the YouTube videos		See first paragraph
Write the script for the videos		See first paragraph
Get approval from the BCHD Executive management		See first paragraph

Develop the videos		See first paragraph
Get approval from the BCHD Executive management and the Maryland Community Review Board		See first paragraph
Release the videos on the Baltimore Status Update website		See first paragraph

4. Formation of HPG

Goal: Develop a HIV Planning Group and Commission that provides community and expert input to achieve integrated, comprehensive, and coordinated strategies to address the HIV epidemic in Baltimore City.

Objectives	Responsibility	Progress and Barriers
Develop strategies to recruit and retain HPG members that reflect diversity of HIV-infected people and key prevention, care and related services.	STD/HIV Prevention Program Staff	The HPG convened for an initial meeting and orientation provided by the National Minority AIDS Council on November 22, 2013.
Bring these members together to participate in a comprehensive engagement process.	STD/HIV Prevention Program Staff	We began this process with training in November of 2013.
Review existing prevention and Ryan White Planning Council comprehensive plans.	STD/HIV Prevention Program Staff	Since the training in 2013, the HPG has focused on prevention and prevention with positives, including linkage to care. The linkage to care process is currently the primary area of overlap.
Cross tabulate the plans to identify common themes.	HPG Members STD/HIV Prevention Program Staff	Considering the many aspects of prevention work that are under consideration, such as PREP, billing, and outreach to youth, this is an unduly ambitious goal at this time. We suggest that this be revisited near the end of the project period when: 1. The expectation is that these two plans and functions will be merged. 2. It will be clearer what the Ryan White Program is going to look like after two more years of experience with the

		Affordable Care Act.
Based on these common themes consider developing a plan that can be used to incorporate and guide prevention and care.	HPG Members STD/HIV Prevention Program Management Ryan White Planning Council	This will be a requirement in the next project period.
Seek T/A to discuss the advantages and disadvantages of creating a single body for prevention and planning.	HPG Members Ryan WhiteRegional Planning Council STD/HIV Prevention and Planning Staff	We will seek this TA near the end of the project period.
At the end of each project year, the HPG and BCHD will elicit input in the development and implementation of the jurisdictional plan from HPG members and other stakeholders and providers.	STD/HIV Prevention Program Management Assistant Commissioner	This is a continual process. It is primarily fueled by the heavy involvement of and high level of effort of the HPG members.

5.1. Information Systems Infrastructure

Goal: Develop an integrated information system that maximizes the efficiency and effectiveness of the HIV Prevention and Care continuum.

Objectives	Responsibility	Progress and Barriers
Complete the migration of STD-/MIS to PRISM.	PHPA STD/HIV Management	This project is grossly behind schedule, primarily due to understaffing and dependence on an out of state contractor.
Complete the Laboratory Information Management system so that it electronically transfers information to Insight.	STD/HIV BDC Laboratory Management Adsavia Contractor	This project is also behind schedule; however, completion is expected by the end of 2014.
Complete the Laboratory Information Management system so that it receives lab requests from and returns results electronically to Ahlers.	Family Planning BDC Laboratory Management	We expect this project to be completed six months after the above project is completed, so hopefully by July of 2015.
Complete migration of Baltimore-specific tables and functionality from STD/MIS to PRISM	STD/HIV Management BCHD MIS	This is a step-by-step process. Each step is contingent on the previous set of steps. With this in mind, it is likely that these steps will not be completed until the end of 2015. It is important to note that all of the procurement issues have been overcome. These issues took up an extra and totally unexpected 12 months.
Complete Laboratory Information Management system so that it receives lab requests from and returns results electronically to PRISM.	STD/HIV Management Adsavia Contractor	
Develop the capability to send results from outreach testing vehicles via VPN version of PRISM to BDC laboratory so that	STD/HIV Management	

it receives lab requests from and returns results electronically to the outreach testing component of PRISM.	Adsavia Contractor	
Develop interfaces between BDC Laboratory and FQHCs and other clinics that allow for automated laboratory order entry.		

5.2. Data Sharing

Goal: Develop a seamless flow of information between PHPA HIV surveillance and BCHDSTD-HIV Prevention surveillance so BCHD responses to surveillance data are occurring in real time.

Objectives	Responsibility	Progress and Barriers
Review data security confidentiality criteria to determine what gaps in compliance exist.	Surveillance Team	This process was completed in 2012.
The lack of appropriately secured space is a known problem. Determine and implement a means to secure space in order to achieve compliance.	Assistant Commissioner Health Department Senior Staff	The space has been secured, requiring a wall to be built and simplex locks to be installed. Sign in procedures have been implemented.
Secure space through construction or moving staff.	Assistant Commissioner Health Department Senior Staff	The space was secured in early 2013.
Develop an MOU with PHPA to allow read-only secure access to eHARS data and PHPA access to STD/HIV databases once space and any other issues have been addressed.	STD/HIV Prevention Program Management PHPA Surveillance staff	This objective has not been met because this process cannot commence until the PRISM project is completed.
Commence and continue real-time access to PHPA and STD/HIV databases.	STD/HIV Prevention Program Management PHPA Surveillance staff	This process cannot commence until the PRISM project is completed.

5.3. Correctional Facilities

Goal: Through a collaborative process with the Department of Public Safety and Correction Services (DPSCS), DHMH HIV/STD/TB and Hepatitis program (DHMH), and BCHD STD/HIV/TB and Hepatitis program (BCHD), develop and implement a strategy to ensure the HIV testing, access to care, and post-release access to care are widely and easily accessible.

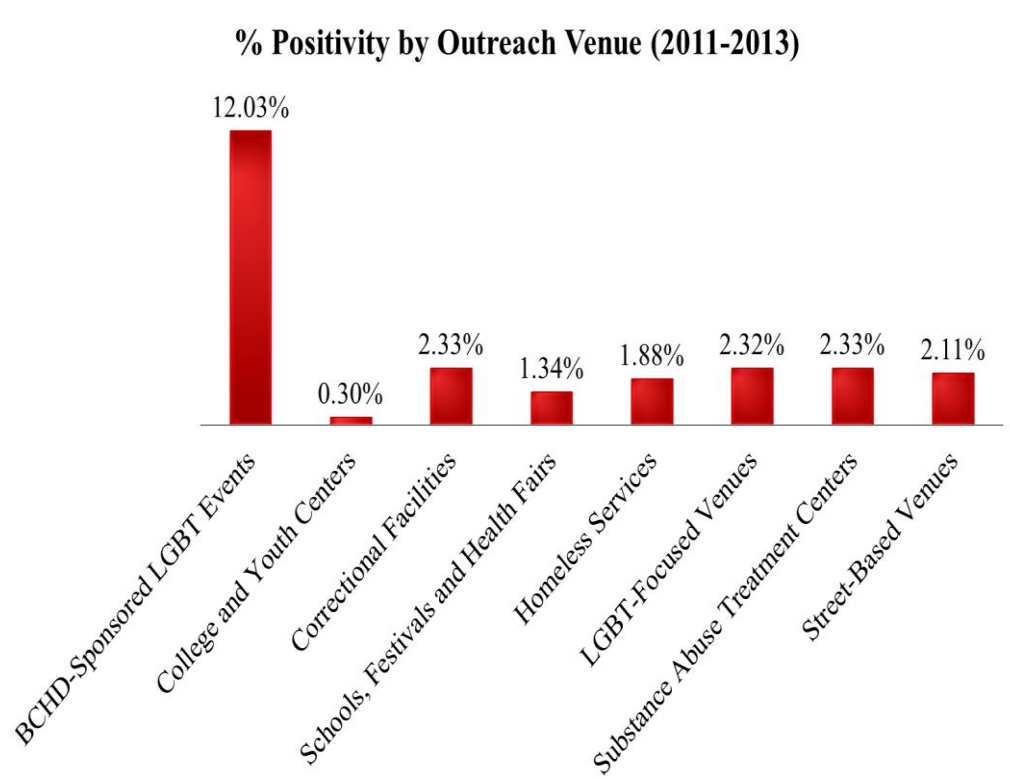
Objectives	Responsibility	Progress and Barriers
Through the HIV Planning Group and Commission (HPG), develop a Corrections workgroup consisting of staff from DPSCS, DHMH, and BCHD	DPSCS DHMH BCHD	The Corrections workgroup was formed on March 20, 2014.
Convene a series of meetings with representation from all the programs described above.	DPSCS DHMH BCHD	The first meeting between DPSCS, DHMH, and BCHD was held on June 3, 2014.
Automatic sharing of the correctional HIV data directly with the commission.	DPSCS Members of Corrections Workgroup HPG	The DPSCS members of the Corrections workgroup will share the correctional HIV data with members of the HPG.
Develop an electronic interface that could allow seamless exchange of reentry and testing data of mutual clients.	DPSCS DHMH	DPSCS is a member of CRISP as well as the health information exchange. This exchange of reentry and testing data is currently under discussion with DHMH state lab.

	BCHD	
Assess completion of objectives and repeat process above for new objectives, such as increasing the percentage HIV positive inmates who have met with a Ryan White Case Manager at least once prior to release.	DOC Coordinator and Assigned Committee PHPA STD/HIV Program Staff Assigned to DOC	Ongoing

5.4. Substance Abuse Treatment

Goal: Ensure that street level HIV testing and HIV testing at Substance Abuse Treatment Centers is widely available and coordinated.

Objectives	Responsibility	Progress and Barriers
Continue to provide street-level testing in high incidence drug trafficking areas.	STD/HIV Prevention Program CBO Contractors	This activity is ongoing; probably at least half of the 14,000 tests conducted annually by BCHD and funded CBO outreach partners are completed in areas with high levels of substance abuse.
Continue to fund a testing FTE for the Needle Exchange Program.	STD/HIV Management	This commitment has been implemented and will continue as long as needed.
Meet quarterly with BHSB, PHPA, and BCHD STD/HIV management staff to coordinate testing efforts in substance abuse treatment facilities.	STD/HIV Prevention Program Management PHPA HIV Management BCHD STD/HIV CBO Partners Throughout The No Wrong Door Project Period	BCHD staff attends this meeting quarterly with an eye toward understanding what resources will be required to maintain successful testing programs.
Develop expectations for an acceptable level of screening coverage at substance abuse treatment centers, and determine and distribute responsibility for HIV screening.	BHSB PHPA STD/HIV Prevention Program Management	Meetings to make this determination still need to occur.

Implement system to continually assess screening coverage and the effectiveness of testing to identify new HIV positive patients.	STD/HIV Prevention Program Management	A higher level of evaluation is probably needed; however, the table below provides initial data for consideration: 
Implement meeting schedule to adjust testing efforts based on review of the monitoring system described above.	STD/HIV Prevention Program Management	We are currently working diligently to incorporate the data collected from our Category C project into our testing practices. Once this information is managed

		in a routine manner, we will further refine the targeting of our overall testing efforts.

5.5. Mental Health Services

Goal: Develop a process to ensure that residential mental health services providers are aware of services available from STD/HIV Prevention and that those services (HIV/STD Education and Testing) are provided when requested.

Objectives	Responsibility	Progress and Barriers
Community Health Educator contacts BHSB and receives a list of mental health residential treatment providers.	Community Health Educator	Our Community Health Educator retired in April of 2014. We are contracting with the Adolescent Reproductive Health Program to provide health education services. We will implement the rest of the steps once this program is in place and operating effectively. In addition, the No Wrong Door Project is providing services to mental health providers as well.
Community Health Educator contacts each residential treatment provider and describes services available	Community Health Educator	
Community Health Educator provides HIV/STD presentations as needed and requested	Community Health Educator	
Provide onsite testing as needed/requested	Community Outreach Supervisor	
Reiterate process above	Community Health Educator Community Outreach Supervisor	

5.7. Private Sector Collaboration

Goal: Increase the number and proportion of HIV-positive people who are found through routine HIV screenings in private medical sector settings.

<table>
<tr><th>Objectives</th><th>Responsibility</th><th>Progress and Barriers</th></tr>
<tr><td>Review the data to compare the risk profile of persons found in private sector settings with those found through outreach and STD Clinic settings.</td><td>Epidemiology Staff</td><td>While we don’t have risk factor data for many private sector settings, an important question is would the people tested in Emergency Departments have been encountered elsewhere, such as in our STD Clinics or through our outreach screening. The table below shows that 65% of those tested in emergency departments had no previous history in other public settings, such as in our STD Clinics.

<table>
<tr><th></th><th>Previously tested</th><th>Not previously tested</th><th>Total</th></tr>
<tr><td>New positives</td><td>24 (35%)</td><td>44 (65%)</td><td>68</td></tr>
<tr><td>Previous positives</td><td>49 (98%)</td><td>1 (2%)</td><td>50</td></tr>
<tr><td>Discordants</td><td>5 (45%)</td><td>6 (55%)</td><td>11</td></tr>
<tr><td>Total</td><td>78</td><td>51</td><td>129</td></tr>
</table>
</td></tr>
</table>

Develop training on the need for STD and HIV screening, based on Baltimore data.	STD/HIV Prevention Training Center Staff	This training is behind schedule, but still planned.
Implement training for Baltimore City Providers.	STD/HIV Prevention Training Center Staff	We plan to complete at least one such training before the end of the calendar year.
Incorporate testing and risk information into the HIV testing toolkits being developed for Physician Detailers in the Category C grant to encourage private testing.	STD/HIV Program Management Category C Management	This has been done. The detailing kits have been well received and distributed to 154 providers and 70 clinic/practice managers since detailing began in the spring of 2014.
Continue meetings of the reimbursement task force until reimbursement is no longer an issue.	Reimbursement Task Force	BCHD continues to work with numerous coalitions to advocate for reimbursement for routine screening for HIV. For example, on 7/22/14, BCHD staff met with hospital executives to better understand and begin to address the barriers to routine screening in hospital in emergency rooms.
Pursue legislation to mandate reimbursement for routine HIV screening in Baltimore, if that is a recommendation of the task force above.	BCHD Legislative Liaison	This is contingent on the recommendations of the task force and assessment of the views the private medical community as a whole.
Continue to compare reported risk of patients reported from the private medical sector annually using risk data gathered from HIV interviews in PRISM	Epidemiology Staff	This endeavor is contingent on completion of the conversion of STD/MIS to PRISM. (See section on information systems).

Provide feedback on risk profiles to private medical community	STD/HIV Prevention Training Center Staff	See section on information systems.

5.8. CBO Capacity

Goal: Increase the breadth and depth of CBO capacity and encourage collaboration so that responses to RFAs are more successful and the programs CBOs can implement are more comprehensive and robust.

Objectives	Responsibility	Progress and Barriers
Seek technical assistance from CDC-funded CBA and TA providers on issues like financial management, board development, proposal writing, fiscal management.	STD/HIV Prevention Program Management	A CBA request was sent to CDC in 2013.
Implement CBA and technical assistance training.	STD/HIV Prevention Program Management	In the winter of 2014, the House/Ball coalition received technical assistance on organizing from a CBA provider. Unfortunately, this provider's contract ended in March 2014. In June 2014, we were notified of a new provider who will take up this effort.
Work with BCHD fiscal department to increase the timeliness of the contracting process or fund a fiscal intermediary to provide fiscal management for CBO contracts.	STD/HIV Prevention Program Management BCHD Fiscal Management	The contracting process has sufficiently improved, so that we will not be hiring a fiscal intermediary. We will continue to work to improve the time frames required to complete contracts.
Write RFAs with clear objectives that encourage collaboration.	STD/HIV Prevention Program Management.	We have not written any new RFAs in this project period.
Participate in CBO-sponsored capacity building and	STD/HIV Prevention	When the CBA from CDC is reinstated, we will be

collaboration enhancing meetings	Program Management Broad group of CBOs	integrally involved. The capacity building is specifically targeted at the house-ball community, however.
When outside funding, such as direct funding from CDC becomes available, provide proactive, egalitarian support to CBOs wishing to apply.	STD/HIV Prevention Program Management	The next announcement is expected before October. We are beginning to develop a strategy on how to approach this.

5.9. Human Resources/Personnel Capacity

Goal: Ensure an adequate staffing level to address the goals, objectives, and tasks of the STD/HIV Prevention Program.

Objectives	Responsibility	Progress and Barriers
Assess how many EBI interventions we expect to actually be funding.	STD/HIV Prevention Program Management	This has occurred. We are currently funding two evidence-based interventions with HIV positive persons and one with high risk HIV negative persons. The two positive interventions are aimed at homeless persons and HIV positive African-American MSM. The HIV negative intervention provides prevention education to African-American transgender persons.
Assess current staffing aptitude, interest and qualifications to monitor and evaluate the effectiveness of EBIs.	PHPA Staff STD/HIV Prevention Program Staff	Project officers from BCHD are now assigned to each of these interventions.
Given staff interest, obtain technical assistance from PHPA staff and CBA providers regarding implementation and monitoring and evaluation of EBI programs.	PHPA Staff STD/HIV Prevention Program Management CDC	Meetings with PHPA have been held. In addition, the contractors have all learned to input the data from their programs directly into CDC's Evaluation Web software. This will improve access to the data and reduce logistical problems with reporting the data to CDC.
Implement monitoring and evaluation of funded EBIs, primarily prevention with positives.	STD/HIV Prevention Program Management	Monitoring is ongoing.

Hire a local first line supervisor for partner services management	STD/HIV Prevention Program Management	See Partner Services Section.
Budget for local staff to continue taking on roles of CDC-assigned senior management.	STD/HIV Prevention Program Management	Local staff increasingly takes responsibility for writing and monitoring grants. By the completion of this project year, it is anticipated that the local staff that can be hired within the project budget will be: • One Perinatal Nurse Coordinator • Two First Line Supervisors • One Program Compliance Officer/Accounting Assistant • One Computer Programmer • 0.5 shared Database Manager for PRISM
Develop and implement training opportunities for local staff in roles of CDC-assigned senior management	STD/HIV Prevention Program Management Assistant Commissioner	Ongoing
Work with human resources to develop a promotional path.	STD/HIV Prevention Program Management	Management continues to work on this; however, it is a difficult undertaking in a government setting.

7. Appendices*

Appendix A: Memo on Implementation of the Syringe Exchange Legislation*

MEMORANDUM

To	Jacquelyn Duval-Harvey, Patrick Chaulk, Valerie Rogers, Shannon Mace-Heller,
From	Amy Samman
Subject	Implementation of the Syringe Exchange Legislation

During the 2014 General Assembly Legislative Session a bill passed transitioning the Health Department's very successful Syringe Exchange Program from a one-for-one exchange to needs based model. This new model will be effective **October 1, 2014**. A link to the passed bill is here: http://mgaleg.maryland.gov/2014RS/bills/hb/hb0354T.pdf

During the legislative session, the Baltimore City Senate Delegation asked that we cap the number of syringes exchanged at 50 through regulation. Dr. Barbot agreed to do so through a letter of intent to the City Delegations. The body of the letter is below (a copy can be found in my 2014 General Assembly file on the share drive).

> I am writing to you to express my appreciation for your support of SB 263, *Baltimore City – AIDS Prevention Sterile Needle and Syringe Exchange Program*. The transition from a one-for-one syringe exchange to a needs-based syringe distribution model will allow our program to implement the standard of care for harm reduction that is practiced in cities across the United States. It will increase access to sterile syringes and will reduce reuse and sharing of contaminated syringes which surveys of our clients have indicated is a serious issue. This will serve our ultimate goal of further reducing the incidence of HIV and Hepatitis C in Baltimore City.
>
> Additionally, this letter serves to notify you of my intent to promulgate regulations following the enactment of this legislation to ensure no more than 50 sterile syringes are exchanged for every one used syringe that is brought to us by our clients.
> Our goal is to ensure our clients have adequate sterile syringe coverage between their visits to our program. We are confident that this can be accomplished with the transition to a needs-based model.
>
> Thank you again for your support and please let me know if you need any additional information.

This regulation will need to be promulgated and the Delegations through Mary Pat Fannon in the Mayor's Office should be notified.

Additionally, there were concerns raised by Committee members and Delegation members about syringe disposal. We put together a memorandum on what we will do to ensure safe disposal as well as promising to do surveillance at the time of implementation. I have included that information below.

Safe Disposal of Syringes

- The program employees will instruct Clients to return syringes to the SEP whether or not the syringes were furnished by SEP.
- Instructions for safe disposal of syringes will be provided to all clients both verbally and in writing, especially those who indicate they may not be able to return syringes because of special circumstances (e.g. increased scrutiny by law enforcement, homelessness, residence has small children, etc.).
- SEP staff will educate participants on the appropriate type of plastic containers that should be used for syringe disposal as follows:
    - (1) Clients will be instructed in how to make their own sharps containers to safely dispose of used syringes with their household garbage. Used sharps may be placed in a plastic, puncture resistant, screw top, container (detergent, soda or bleach bottle). The puncture resistant container must be closed securely and sealed with tape. The container must be labeled "contains sharps" before it is discarded in the trash and should never be placed with items being recycled. Clients will be also provided with illustrated pamphlets that explain how to make, seal, and label their containers.
        - http://www.baltimorehealth.org/Disposal%20Brochure.pdf
    - (2) Personal sharps containers will be provided to clients who indicate that they do not have access to appropriate puncture resistant plastic containers with which to make their own sharps containers.
    - (3) Clients will be provided with a list of locations and hours of hospitals where they may dispose of their used syringes. (We currently have clients who say they are permitted to dispose of sharps at Bayview.)
- SEP staff will educate clients on inappropriate methods of syringe disposal such as the following:
    - breaking off the tip and discarding in trash; disposal on the street or other public venues;
    - disposal of used syringes in household garbage without first containing them in sealed, labeled plastic puncture resistant containers;
    - flushing in toilets;
    - disposal of syringes in the trash in glass jars or coffee cans.
- SEP staff will explain and provide handouts to clients that these inappropriate disposal methods put members of the public such as sanitation workers at risk for needle stick injuries.

Surveillance of Exchange Sites

Before the transition from 1-for-1 exchange model to a need-based distribution model the managers of the syringe exchange will make visits to the areas immediately surrounding each of the sites where the SEP mobile vans operate to establish a baseline for inappropriate disposal of syringes at each site. They will look for syringes that clients may have disposed of inappropriately, record the number of syringes found near each site, and remove them for safe disposal. During the year following the transition from 1-for-1 exchange model to a need-based distribution model, the managers of the syringe exchange will make monthly visits to these areas so that they may look for syringes, document the number found, and remove them for safe disposal.

After one year of surveillance, the SEP will present its findings to the SEP Oversight Committee. If there has not been an increase in the number of improperly disposed of syringes in the areas around the SEP sites, the SEP Oversight Committee will determine next steps.

Finally, included in the legislation is a reporting requirement, similar to the one required for the Expedited Partnership Therapy Program.

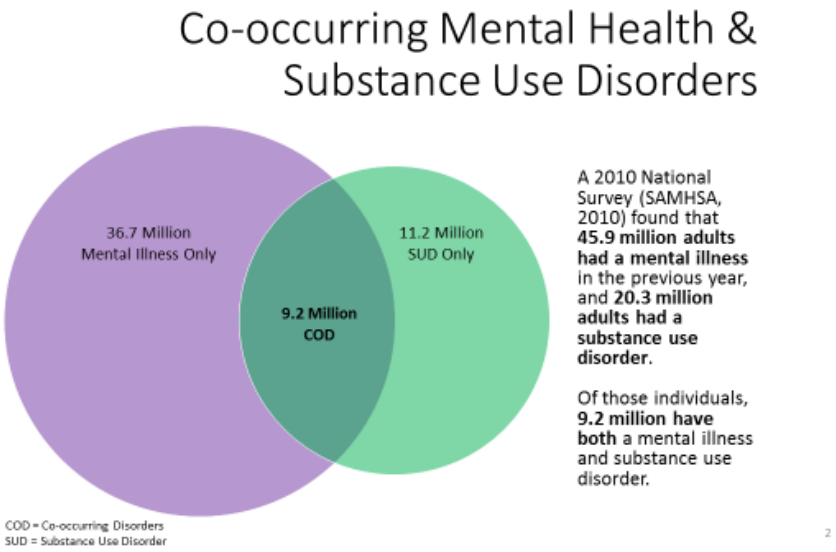
Reporting Requirements:

- "On or before December 31 of each year, the Baltimore City Health Department shall report to the Oversight Committee, the Governor, and in Accordance with §2-1246 of the State Government Article, the General Assembly, on the number of Hypodermic Needles and Syringes exchanged as part of the program."

Appendix B: National and State Data on Behavioral Health*

National Data

The Substance Abuse and Mental Health Services Administration (SAMHSA) identified the co-occurrence of mental health and substance abuse disorders in a national study conducted in 2010:

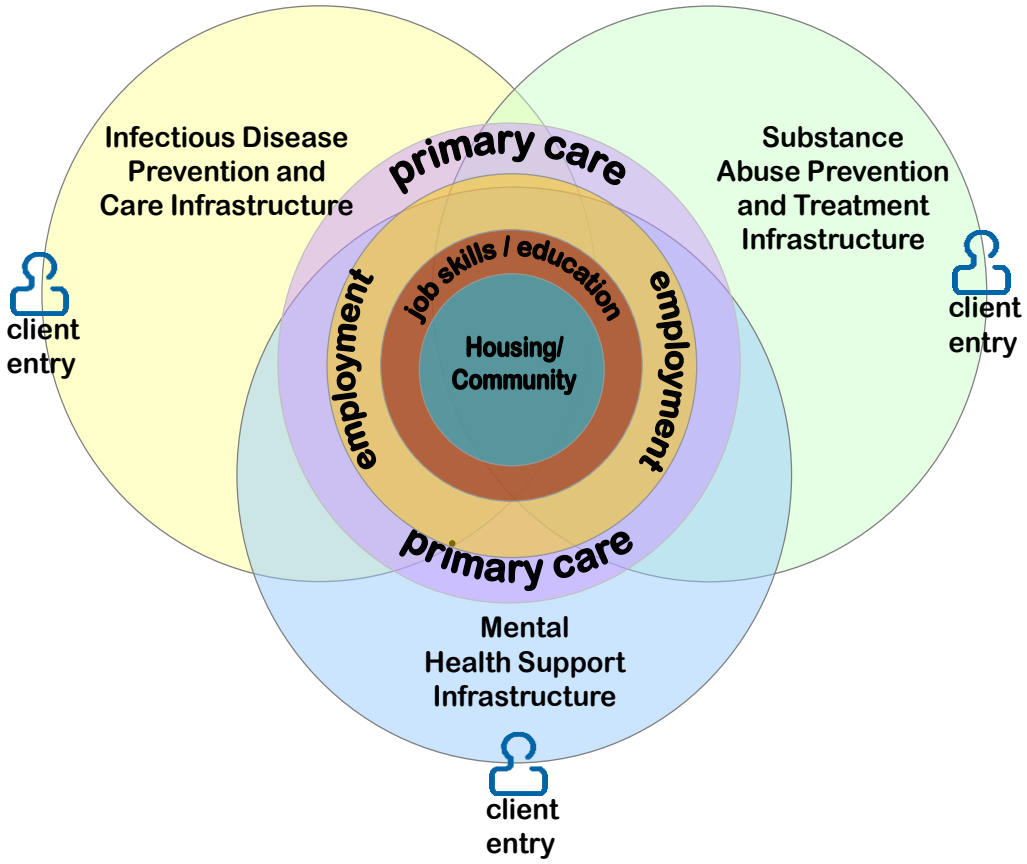


State Data

The Maryland Alcohol and Drug Abuse Administration reported a higher co-occurrence of behavioral health disorders among persons admitted to the publicly-funded substance abuse treatment system in Maryland during fiscal year 2012: 45.7% of substance abuse treatment clients had a co-occurring mental health disorder.

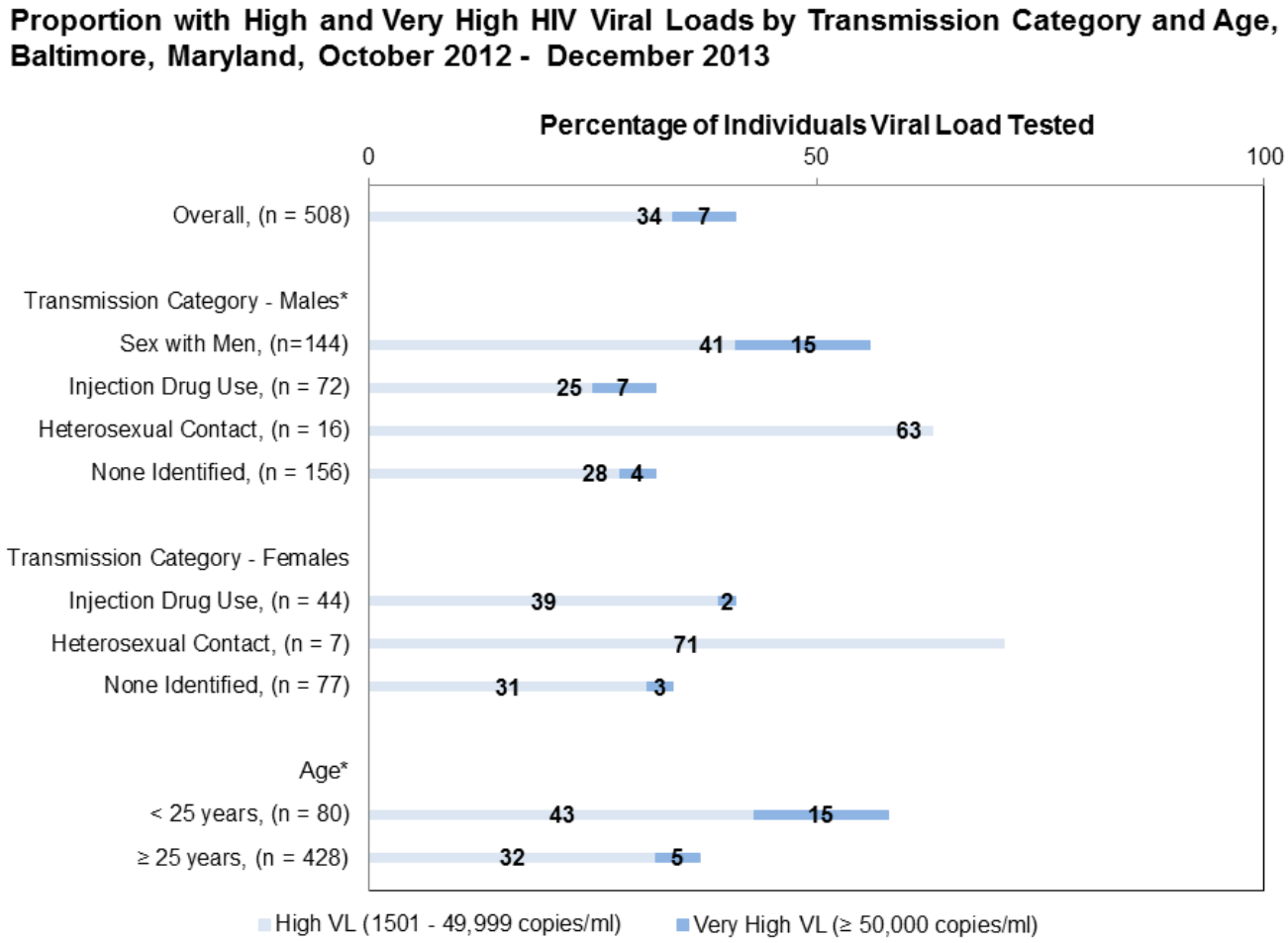
Appendix C: The No Wrong Door Project Diagram*

The No Wrong Door project is designed so that a client may enter through any "door" of the local behavioral health and infectious disease systems and find their way to all of the other services they need across disciplines:



Source: Abraham, M.R., Wakhweya, A.M., Castner, K., and Brevelle, J.M.

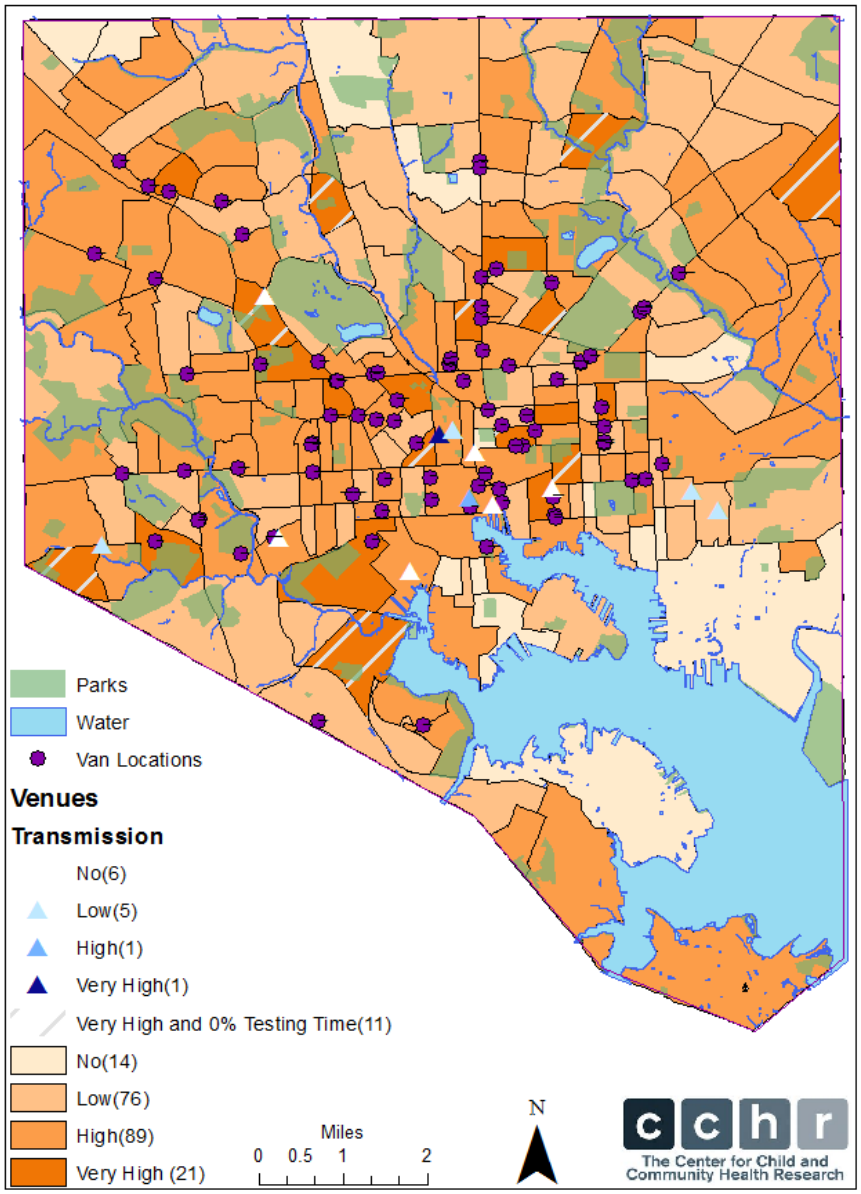
Appendix D: From the Category C Detailing Project: Proportion with High and Very High Viral Loads by Transmission Category and Age, Baltimore, MD, October 2012 – December 2013*



*p < 0.05

Appendix E: From the Category C Detailing Project: Overall High Transmission Areas and BCHD Night Team Outreach Testing April – August 2013*

Night Team Outreach Testing at Census Tract, April –August 2013



Source: Maryland Department of Health and Mental Hygiene, Baltimore City Health Department